



National Association of School Nurses

Position Statements

Issue Briefs

Resolutions and Consensus Statements

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Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the safe and effective management of allergies and anaphylaxis in schools requires a collaborative, multidisciplinary team approach. The registered professional school nurse (hereinafter referred to as the school nurse), is the leader in a comprehensive management approach which includes planning and coordination of care, educating staff, providing a safe environment, and ensuring prompt emergency response should exposure to a life-threatening allergen occur. Furthermore, NASN supports, in states where laws and regulations allow, the maintenance of stock non-patient specific epinephrine and physician-standing orders for school nurses to administer epinephrine in life-threatening situations in the school setting.

School districts must have a clear, concise, all-inclusive policy in place to address the management of allergies in the school setting that should be reviewed annually (National School Boards Association (NASB), 2010). This policy shall be consistent with federal and state laws, nursing practice standards and established safe practices in accordance with evidence-based information and include development of a developmentally appropriate Individualized Healthcare Plan (IHP) and Emergency Care Plan (ECP).

HISTORY

Food and insect sting allergies that may result in anaphylaxis, a potentially life-threatening allergic reaction, have been diagnosed with an increased frequency (Branum & Lukacs, 2009). Food allergies have soared in school-age children and now affect 1 in every 25 students, which is an increase of 18% from 1997 to 2007 (Young, Munoz-Furlong, & Sicherer, 2009).

Food allergies induce 30%-50% of anaphylaxis cases (Cianferoni & Muraro, 2012). The eight most common food allergies that account for 90% of food allergy reactions are milk, eggs, peanuts, tree nuts, fish, shellfish, soy, and wheat (National Institute of Allergy and Infectious Diseases [National Institute of Allergy and Infectious Disease (NIAID), 2010). Children with food allergies are 2-4 times more likely to experience other allergic reactions and asthma than those without food allergies (Branum & Lukacs, 2008).

DESCRIPTION OF ISSUE

Anaphylaxis is a severe allergic reaction that has a rapid onset and may be fatal. During anaphylaxis, tissues in the body release histamines that cause the airways to tighten and lead to many systemic symptoms, the most important being those that are life threatening, e.g. difficulty breathing and swallowing, systemic hives, feelings of impending doom, wheezing, decreased blood pressure and loss of consciousness. Common causes of anaphylaxis are medications (i.e. antibiotics), foods, natural rubber latex, and insect bites/stings (Kim & Fischer, 2011). Cold-induced and exercise-induced anaphylaxis, although rare, can also occur. Some people have anaphylactic reactions with unknown causes (MA Department of Public Health Data Health Brief, 2010). Food allergies are the most common source of anaphylaxis in children, whereas adults are more likely to experience venom and drug-induced response (Kim & Fisher, 2011).

Once an infrequent occurrence, anaphylaxis has increased dramatically, and 16-18% of students with food allergies have experienced an allergic reaction in school (Young, Munoz-Furlong, & Sicherer, 2009). Epinephrine administration reports from Massachusetts indicate that approximately 25% of students who experience anaphylaxis were not previously diagnosed with a life-threatening allergy (MA Department of Public Health Data Health Brief, 2010). This indicates a need for non-patient specific epinephrine to be available for use in the school setting, which is supported by NASN, American Academy of Asthma Allergy Immunology (AAAI), American Academy of Pediatrics (AAP) and the Food Allergy Anaphylaxis Network (FAAN) (School Access to Emergency Epinephrine Act, 2011). Prevention of anaphylaxis is vital for identified allergens and begins with avoidance of allergens or treatment of symptoms (NIAID, 2010).

Accidental ingestion of food allergens occurs frequently among students in the school environment. One study reports accidental ingestion of milk protein by children with known milk allergies resulted in a 40% reaction rate with 15% of those reactions being severe (Boyno-Martinez, Garcia-Ara, Pedrosa, Diaz-Pena, & Quince, 2009). Maintaining a healthy environment is essential. All environments in the school setting require special attention to protect students by limiting allergens or providing areas that are allergen safe (National School Boards Association [NSBA], 2011). Completely banning nuts or other foods is not recommended as it is 1) not possible to control what other people bring onto the school grounds, and 2) does not provide the allergic student with an environment where he/she can safely learn to navigate a world containing nuts. When a ban is instituted, parents feel their child will not be exposed to allergens. A ban can create a false sense of security ("Banning allergies from school", 2012).

There are many considerations in the management of an anaphylactic reaction. Biphasic or rebound reactions can occur hours after the initial reaction without a further exposure and affect as high as 20% of individuals who receive epinephrine for anaphylaxis (NIAID, 2010). Epinephrine administration requires immediate activation of Emergency Medical Services, or 911 (Morris, Baker, Belot, & Edwards, 2011; NSBA, 2011).

School staff must not only be aware but also prepared to prevent or respond to an anaphylactic reaction to be effective in supporting a student with a life-threatening emergency (NSBA, 2011). Training must be provided at least annually to school personnel that are involved with the student during the school day, extracurricular activities, field trips and before/after school programs.

Most states have laws allowing emergency medication such as epinephrine to be carried by the students and be self-administered as needed. Several states also have laws supporting the supply and use of stock epinephrine in the school setting for both non-patient specific and diagnosed patient use. When developmentally appropriate, students should be allowed to self-administer and self-manage their allergy.

Allergies have a significant impact on the lives of families. Families with allergies report a higher level of stress for both parents and the child. Parents are anxious about sending their child to school with an allergy. Entering school or changes in the school environment are stressful events, and many parents view these events as opportunities that increase their child's chance of exposure to allergens (Roy & Roberts, 2011).

RATIONALE

Federal laws including the American Disabilities Act, Individual with Disabilities Education Act, and Section 504 of the Rehabilitation Act of 1973 protect the legal rights of students with allergies along with the Food Safety Modernization Act (FSMA) which became law January 2011. These laws protect students' individual rights as well as direct schools to develop voluntary guidelines on food allergy management while they prohibit preempting state laws (FMSA, 2010).

In 1998, the American Academy of Allergy Asthma and Immunology advocated that every student with a food allergy diagnosis have an ECP and a prescription for epinephrine (Carlisle et al., 2010). Schools are responsible for planning and preparing for the complex medical and nursing needs of students. The school nurse functions as the leader in coordinating health services in the school setting (AAP, 2008). As the school health professional, the school nurse is uniquely prepared with the education, experience and expertise to coordinate student health-care, the development and implementation of a comprehensive IHP and ECP with the parents/guardian, health care provider, school staff and when appropriate, the student (Sicherer & Mahr, 2010).

School nurses can decrease the stress and anxiety of parents of children with allergies by working in partnership with families, implementing evidence-based strategies to prevent allergen exposure and preparing school personnel to respond to anaphylaxis, acknowledging parents' concerns, and emphasizing that the school takes allergy seriously (Roy & Roberts, 2011).

Managing allergies and anaphylaxis at school is complicated and multifaceted and is best accomplished through coordination of care within a multidisciplinary team (including but not limited to the student and his or her family, school nurse, teachers, school administrators, nutrition services, and bus drivers) (Carlisle et al., 2010; NASB, 2010). Research shows that schools and childcare settings **with** school nurses are more likely to provide immediate treatment (47% with a school nurse vs. 34% without) and have emergency care plans (62.3% with vs. 39.2% without) in place (Greenhawt, McMorris, & Furlough, 2008). Prompt treatment leads to an increase in positive outcomes (Young, Munoz-Furlong, & Sicherer, 2009). The school nurse is the key school professional to lead the school staff in the awareness, prevention and treatment of life-threatening allergic reactions keeping students safe at school and ready to learn.

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SUMMARY

It is the position of the National Association of School Nurses (NASN) that schools should employ professionally prepared Registered Nurses, to conduct and supervise school health programs which address the variety of health problems experienced by school children. NASN recommends a formula-based approach with minimum ratios of nurses-to-students depending on the needs of the student populations as follows: 1:750 for students in the general population, 1:225 in the student populations requiring daily professional school nursing services or interventions, 1:125 in student populations with complex health care needs, and 1:1 may be necessary for individual students who require daily and continuous professional nursing services. Other factors that should be considered in the formula-based approach are number of students on free or reduced lunch, number of students with a medical home, and average number of emergency services per year.

HISTORY

The school nurse functions as a leader and the coordinator of the school health services team. The American Academy of Pediatrics (AAP) emphasizes the crucial role school nurses have in the seamless provision of comprehensive health services to children and youth as well as in the development of a coordinated school health program. The AAP acknowledges that the school nurse facilitates access to a medical home for each child and coordinates a school health program that meets the needs of the whole child and supports school achievement (American Academy of Pediatrics [AAP], 2008). It continues to be the goal of NASN to provide children and youth with access to the primary school health care resource, the school nurse.

There are a wide variety of factors that have historically affected the school nurse to student ratios. These include insufficient funding for school health services, local acceptance and understanding of the school nurse role. School districts across the nation use various models to deliver school health services. To date, 45% of public schools have a school nurse all day, every day, with another 30% working part time in one or more schools (NASN, 2007). Caseloads vary widely, between states and within states. Throughout the nation, many school nurses provide health services to multiple school buildings, limiting the access that students have to a school nurse. When there is no registered nurse on the school premises, the responsibility to administer the necessary medications and treatments, and appropriate monitoring of the children falls on the shoulders of administrators, educators, and staff that are ill-prepared to perform these tasks (ANA, 2007).

DESCRIPTION OF ISSUE

Currently 98% (52 million) of the nation's school children spend their day in schools (NCES, 2008). Notably 16% of the 52 million students have chronic physical, emotional or other health problems. Students today face increased social issues as well as the need for preventative services and interventions for acute and chronic health issues (AAP, 2008). Factors that impact the need for a more comprehensive delivery of health care services in schools include:

- The IDEA/Individuals with Disabilities Education Act Federal law and the Section 504 provision of the Vocational Rehabilitation Act which mandate health-related services to children and adolescents in school (Section 504, 2005; IDEA, 2004).
- An increase in the number of children with complex health problems. Overall, 15% to 18% of children and adolescents have a chronic health condition (Perrin, 2007). From 2002 to 2008, the percentage of children in special education with health impairments, due to chronic or acute health problems, increased 60% (Bloom, 2009). Within

this group, the rate of children with autism has doubled since 2002 (Bloom, 2009). A 40% increase in asthma has been seen in the past ten years (Levy, 2006), along with nearly 50% increase in the incidence of diabetes in the same time period (CDC, 2009).

- The Centers for Disease Control and Prevention report that the percentage of children without health insurance was 8.9% in 2008 (CDC, 2009). With over 1.3 million homeless children in our country, schools have become the only source of health care for many children and adolescents.
- Language barriers face many families, including the children of immigrants. Families that face barriers of communication have been found to be less likely than others to have a usual source of medical care (Flores, 2006).
- Availability of affordable health care in the community may affect the need for school health services (RWJF, 2009).
- Communicable and infectious diseases impact school attendance and require school nurse surveillance and reporting. "Infectious diseases account for millions of school days lost each year for Kindergarten through 12th grade public school students in the United States: 40% of children aged 5-17 years missed 3 or more school days in the past year because of illness or injury" (CDC, 2009). School nurses have a positive impact on immunization rates with fewer parent requested exemptions (Salmon, 2005).

RATIONALE

Every student in our schools, where instruction and learning are the primary goals, benefits from the assessment and treatment skills of a school nurse to keep him or her in the classroom and ready to learn. Students at risk for educational failure may have social, emotional, or physical health concerns that must be addressed before optimal achievement can take place.

School nurses use assessment and intervention skills to keep students in classrooms where education takes place. One study's results showed that school nurses attended to 64% of a given student population (grades 1 – 12) and returned 95% to class as opposed to the non-licensed staff that saw 36% and returned 82% to class (Pennington, 2008). A similar separate study result showed that students were two times as likely to leave school early on days that the school nurse was not in the building (Wyman, 2005).

The National Association of School Nurses suggests measuring nurse staffing requirements using a caseload assignment formula. In the example below, of an abbreviated caseload formula, the student population is 1000. One medically fragile student requires mechanically supported breathing with a ventilator. Three students require feedings through a gastrostomy tube inserted through their abdomen; five students have insulin dependent Type 1 diabetes; 50 students have serious asthma or allergies requiring monitoring and medication; three students require urinary catheterization; and nine have other complex needs. One hundred thirty students require medication during the school day. The remaining 797 students have state mandated health screenings (vision, hearing, BMI, etc.) and health promotion and periodic health care needs. (Garcia, 2009)

<i>Ratio</i>	<i>Number of Students</i>	<i>Divided by</i>	<i>Equals</i>
1:1	1	1	1
1:125	72	125	0.58
1:225	130	225	0.58
1:750	797	750	1.06
Total Nursing Needs:			3.2 School Nurses
Ratio for this school population:	Nurses/Total Students		1:313

The utilization of this type of formula illustrates the importance of considering the individual medical needs of students in establishing appropriate school nursing coverage. Therefore, the National Association of School Nurses strongly urges each state to mandate a maximum caseload, based on student acuity levels, with funding attached to the mandate.

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Child Mortality in the School Setting



Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that data on children's deaths in school should be recorded, analyzed and reported at the local, state and national level. The systematic review of data on child deaths is necessary to drive interventions and policies that will decrease mortality from injuries, violence, acute illness and chronic disease in the school setting (Bergren, 2010; Christian & Sege, 2010).

HISTORY

Schools are not immune from the threat of fatal injury or death of school-age children. Schools today provide care for an increasing number of chronically and acutely ill children. Medically fragile children in school require ventilators, tube feedings, medication, and other complex nursing care procedures (Allen, Henselman, Laird, Quinones, & Reutzel, 2012; Bergren, 2011). Ten percent of school-age children have asthma (Centers for Disease Control and Prevention [CDC], 2011a). Diabetes is one of the most common chronic diseases in children and adolescents, affecting 151,000 children (CDC, 2011b). The prevalence of anaphylactic food allergy among children under age 18 increased 18% from 1997-2007 (Branum & Lukacs, 2008). Overall, 15% to 18% of children and adolescents have a chronic health condition (Perrin, Bloom & Gortmaker, 2007). School children are at risk of injuries in classrooms, gyms, playgrounds and playing fields. Drug and alcohol overdoses, suicide, violence and homicide can also occur at school (American Academy of Child and Adolescent Psychology [AACAP], 2011).

DESCRIPTION OF ISSUE

There is a dearth of data surrounding the health of the 49.4 million students who attend school every day (National Center for Education Statistics [NCES], 2011). While voluminous amounts of data are reported in various national health data bases on children in hospitals, clinics and primary care offices, data is not collected or analyzed on a national level about the intensity or quality of health care that is delivered in school every day (Lear, 2007).

The lack of data on students' health also extends to a corresponding lack of data on student deaths. In the United States, deaths of employees that occur at work are monitored and investigated by the Occupational Health and Safety Administration (OSHA). OSHA can specify that exactly 4,547 United States workers died on the job in 2010 (Bureau of Labor Statistics, 2012). However, the number of children who die at school or who die following an adverse event at school is unknown. A few states, including North Carolina and Massachusetts, collect and publish public data on chronic and acute health conditions of students in public schools (Massachusetts Department of Public Health, 2011; North Carolina Healthy Schools, 2011). However, many states do not collect that data and no national repository exists on child deaths at school and whether they are accidental or due to disease or violence.

RATIONALE

Preventable child deaths are classified as "never events" (Agency for Health Research and Quality [AHRQ], 2012). A never event is a rare, devastating, preventable adverse event (National Quality Forum [NQF], 2007). While there are widespread initiatives to eliminate devastating "never events" in healthcare settings, there is not a similar broad effort to address dire outcomes in the school setting due to the lack of data. The systematic review of child deaths in school is needed to identify strategies to create population data driven interventions for a safer school environment for all children. The increasing number of students receiving health services for serious health conditions requires vigilance to prevent those conditions from exacerbating, potentially resulting in a preventable child fatality (Malone & Bergren, 2010). Registered professional school nurses need to advocate for the collection and analysis of student health data at the local level and for the reporting and aggregation of student health data at the state and national level in order to advise health and education policy makers (Johnson, Bergren, & Westbrook, 2011 & 2012).

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SUMMARY

It is the position of the National Association of School Nurses that students with chronic health conditions have access to a full-time registered professional school nurse (hereinafter referred to as school nurse). School districts should include school nurse positions in their full-time instructional support personnel to provide health services for all students, including students with chronic health conditions. The school nurse coordinates and conducts assessment, planning, and implementation of individualized health care plans for safe and effective management of students with health conditions during the school day. The school nurse is both the provider of care and the only person qualified to delegate care to an unlicensed care provider as prescribed in state nurse practice laws and regulations and according to Scope and Standards of School Nurse Practice (National Association of School Nurses [NASN] & American Nurses Association [ANA], 2011).

HISTORY

The percentage of children and adolescents in the United States with chronic health conditions (CHC) increased from 1.8% in the 1960s to more than 25% in 2007 (Halfon & Newacheck, 2010). There is some difficulty in measuring prevalence due to the lack of a clear definition of chronic health conditions. CHC include both long-term physical and mental disorders. It is useful to use a non-categorical approach CHC, and for identifying children and adolescents as having special health care needs. These children include those with long-term physical, emotional, behavioral, and developmental disorders that require prescription medications and medical or educational services. They also include disorders that affect a child's functional status (Forrest, Bevans, Riley, Crespo, & Louis, 2011). The non-categorical approach focuses on needs for service and risk of school failure.

Over the past few decades the number of students with CHC in schools has increased for a variety of reasons. Many students who had been confined to therapeutic settings are now being educated in the local school district in the least restrictive environment. Their right of participation is protected by federal law, including the Rehabilitation Act, Section 504 and the Individuals with Disabilities Educational Act [IDEA] of 2004. As survival rates associated with chronic conditions in infants and children continue to increase and life expectancy increases, the health care and educational service needs of students will increase. Many children with CHC now are able to attend school and succeed due to critical support services, including those provided by school nurses. The school nurse is a key member of the educational team and is the one who is responsible for planning, implementing, and monitoring the health care plans for students with CHC.

DESCRIPTION OF ISSUE

The main issues surrounding health management of students with chronic health conditions in schools are as follows:

- Health care services must be provided for students who qualify for services under IDEA or Section 504 to meet requirements of federal laws. The school nurse has an important role in interpreting a student's health status, in explaining the impairment, and in interpreting medical and other health information in relation to the expanded standards for eligibility under Section 504 (Zirkel, 2009).
- Development of individualized health care plans (IHP) is a nursing responsibility and is based on standards of care that are regulated by State Nurse Practice Acts and cannot be delegated to unlicensed individuals (National Council of State Boards of Nursing [NCSBN], 2005).
- Effective and safe management of chronic health conditions is complex, requires careful planning by a school nurse, and may involve delegation of nursing tasks to both licensed and unlicensed assistive personnel (UAP).
- A full-time school nurse is essential to achieve quality student health services and to meet student health needs.

- Dependable funding is required to ensure quality student health services.

RATIONALE

Health care needs of students with chronic health conditions are complex and continuous. School nurses assist many children not served by the health care system and work to create access to health care for students and families. Students who may not have been identified as having a chronic condition prior to school entry are identified by school nurses who then coordinate evaluation and intervention services. School nurses assist students in learning to manage chronic illness, increasing seat time in the classroom, decreasing student absenteeism, resulting in cost savings to the school district and an increase in the overall academic success of the student.

School nurses are responsible and accountable for the assessment of and planning for safe and effective medical management of students with chronic health conditions. These responsibilities cannot be delegated (NCBSN, 2005). Therefore, it is the position of NASN that school districts should provide a full-time school nurse in every school building. NASN recommends school nurse to student ratios based on student populations:

- 1:750 for students in the general population,
- 1:225 in the student populations that may require daily professional school nursing services or interventions,
- 1:125 in student populations with complex health care needs, and
- 1:1 may be necessary for individual students who require daily and continuous professional nursing services.

Additionally, Healthy People 2020 has included an objective to increase the proportion of schools that have a full-time registered school nurse-to-student of at least 1:750 (USDHHS/CDC, 2010).

A full-time school nurse is essential for oversight of the staffing plan and for informing school administrators of current staffing needs (Peterson & Wolfe, 2006).

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This Position Statement replaces the Issue Brief:

School Nursing Management of Students with Chronic Health Conditions (adopted 2006)

See also National Association of School Nurses. (2010). *Position Statement: Caseload Assignments*. Available at <http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/7/Caseload-Assignments-Revised-2010>

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Concussions-The Role of the School Nurse

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that the registered professional school nurse (hereinafter referred to as school nurse) is an essential member of the team addressing concussions. As the school-based clinical professional on the team, the school nurse has the knowledge and skills to provide concussion prevention education to parents, students and staff; identify suspected concussions; and help guide the student's post-concussion graduated academic and activity re-entry process. The school nurse collaborates with the team of stakeholders including health care providers, school staff, athletic trainers, and parents.

HISTORY

The number of school-age children who have sustained concussions increased over the past few years (Bakhos, Lockhart, Myers & Linakis, 2010). Each year, U.S. emergency departments treat an estimated 135,000 sports- and recreation-related traumatic brain injuries (TBIs), including concussions, among children ages 5 to 18 (Centers for Disease Control [CDC], 2007). While falls are the most common cause of these concussions in children, sports-related concussions in school-age children are rising at an increasing rate (Faul, Xu, Wald, & Coronado, 2010; Lincoln, et.al. 2011). Almost half a million emergency department visits for traumatic brain injuries (TBI) are made annually by children aged 0 to 14 years (Faul et al., 2010). This increase in concussions may be due in part to a greater awareness of the condition and its symptoms or increased rates (Lincoln et al., 2011). The actual incidence of concussions may be higher than is currently reported due to lack of standardization in reporting and underreporting (Guskiewicz, Weaver, Padua, & Garrett, 2010; Halstead, Walter & The Council on Sports Medicine and Fitness, 2010). A variety of concussion management guidelines are emerging. For example, the CDC (2009) has developed the Heads Up campaign for concussion prevention and management.

DESCRIPTION OF ISSUE

Concussions are considered to be a mild form of a traumatic brain injury and the potential for their occurrence in children is greatest during activities where collisions can occur, such as during physical education (PE) class, playground time, or school-based sports activities (CDC, 2009). Recognition of a concussion and immediate assessment is critical in preventing further injury and for post-concussion management. Any force or blow to the head and/or symptoms of a concussion in a student or athlete should be immediately evaluated by either the school nurse or designated, trained school personnel. A consensus statement approved by the 3rd International Conference on Concussion states that, although most people recover quickly and fully from a concussion, the time needed is often slower among young children and teens (McCrory et al., 2009). During this recovery phase, the student may have an array of physical, mental, and emotional symptoms, which can impact the student in the school setting. Children with diagnosed concussions require significant cognitive rest and a graduated re-entry plan to pre-concussion activities as determined by the licensed health care provider.

As the student returns to school after a concussion, the school nurse has a significant role in supporting the student. The school nurse collaborates with the parents, school staff, special service providers, the health care professionals, and the student in providing accommodations as the student transitions back to school. A collaborative team approach with all stakeholders involved provides for the best management of the student's post-concussion (CDC, 2010c). The school nurse can initiate an accommodation plan/health care plan based on input from the health care professionals and school staff to provide the cognitive rest and support needed during

recovery. Accommodations during the recovery process may include modifying or limiting school activities (Halstead et al., 2010; Majerske et al., 2008; CDC, 2010c). The accommodations may include allowing rest during the school day, postponing testing until symptom-free, pacing homework or assignments, limited physical exertion, and physical accommodations, as needed. The school nurse can provide on-going monitoring of post-concussion symptoms and act as a liaison with stakeholders. For students who have persistent symptoms, the school nurse can work with the provider and family to facilitate a Section 504 Plan and/or a referral for special education evaluation as needed.

Students are at a risk for increased emotional symptoms post-concussion during the healing process (Halstead, et al., 2010). Furthermore, when cognitive deficits persist, there is an increased risk of psychological symptoms including depression (Ruttan, Martin, Liu, Colella, & Green, 2008). Recognizing the potential for these emotional symptoms in recovering students, the school nurse can provide encouragement and information for the student and school staff that brain healing is a paced process and cannot be speeded as the brain needs time to rest and repair itself.

RATIONALE

It is imperative that appropriate preventative guidelines and post-traumatic procedures are followed. Individualized, conservative management is recommended in treating children's and teens' post-concussion (Halstead et al., 2010; Majerske et al., 2008; CDC, 2010c). Proper management with a suspected concussion includes observation for symptoms, assessment for symptoms, notification to parents/guardians, referral to a health care professional if symptoms are noted, and if no symptoms are present - instructions to parents or school staff for continued observation (CDC, 2010a). As the school health professional, the school nurse provides advocacy for the prevention of concussions by advocating for safe environments; education of students, parents and staff on concussions; and tracking students with concussions (CDC, 2010b).

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National Association of School Nurses

Position Statement Coordinated School Health Programs

SUMMARY OF THE POSITION:

It is the position of the National Association of School Nurses (NASN) that all children should have the right to coordinated school health programs. NASN supports continued research to document the outcomes of these programs. School nurses should use their professional education and skills to assist their schools and communities in the development, implementation, and evaluation of coordinated school health programs.

HISTORY:

The coordinated school health initiative has emerged in response to the state of children's health and education. It is an organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and school staff. The School Health Policies and Programs Study (SHPPS) conducted in 2006 found that most U.S. schools provide basic health services to students but relatively few provide prevention services or more specialized health services. Only 45.1% of all schools had a nurse-to-student ratio of at least 1:750 (Brener, Wheeler, Wolfe, Vernon-Smiley, & Caldart-Olson, 2007). Few schools offered a comprehensive employee wellness program (Eaton, Marx, & Bowie, 2007). A recent systematic review of the literature found some evidence to support a positive effect of coordinated school health programs on academic outcomes for children with asthma and no negative impact on academic performance when children were more engaged in physical activity. There was no evidence to support the effect of staff health promotion programs or school environment interventions on academic outcomes (Murray, Low, Hollis, Cross, & Davis, 2007).

The components of a Coordinated School Health Program include:

- **School health services:** Preventive services, education, emergency care, referral and management of acute and chronic health conditions.
- **Health education:** A planned, sequential K through 12 curriculum addressing the physical, mental, emotional, and social dimensions of health to help students develop health knowledge, attitudes, and skills.
- **Health promotion programs for faculty and staff:** Planned health promotion and disease prevention programs and opportunities for school staff.
- **Counseling psychological and social services:** Services that focus on cognitive, emotional, behavioral, and social needs of individuals and families.
- **School nutrition services:** Integration of nutritious, affordable, and appealing meals, nutritional education, and an environment that promotes healthy eating behaviors for all students.
- **Physical education programs:** A planned, sequential K through 12 curriculum that promotes lifelong physical activity.
- **Healthy school environment:** A safe physical and psychological environment that is supportive of learning.
- **Family and community involvement:** Partnerships among schools, families, community groups, and individuals.

DESCRIPTION OF ISSUE:

School-age children face developmental and social challenges that have an impact on existing chronic conditions, such as asthma and diabetes, and lead to other serious problems such as pregnancy, sexually transmitted diseases, motor vehicle accidents, and suicide. Factors like poverty, lack of parental involvement, and a need for better access to high-quality health care exacerbate these problems. Educating and supporting students, particularly those at high risk, to develop health promoting behaviors and effective coping strategies can improve health and contribute to patterns of healthy behavior that will extend into adulthood. Coordinated school health programs that have a strong emphasis on health education and health promotion are an important strategy to foster student health. However, the intensity and types of school health programs vary considerably from one state to another and within the same state.

ROLE OF THE SCHOOL NURSE:

In a coordinated school health program, the school nurse may provide leadership or play a supporting role in any of the eight components.

- **School health services:** by assessing student health status, providing emergency care, ensuring access to health care, and identifying and managing barriers to student learning.
- **Health education:** By providing resources and expertise in developing health curricula and providing health information.
- **Health promotion for faculty and staff:** By providing health information and health promotion activities, monitoring chronic conditions, and maintaining records.
- **Counseling, psychological, and social services:** By collaborating with counseling staff to identify student psychosocial problems and provide input and intervention.
- **School nutrition services:** By providing education about nutritious foods, monitoring menus and food preparation, and encouraging the inclusion of healthy foods on menus, in vending machines, and for classroom snacks.
- **Physical education programs:** By collaborating with physical educators to meet physical education goals, providing information to students about physical activity, and helping to design appropriate programs for students with special health concerns.
- **Healthy school environment:** By monitoring, reporting, and intervening to correct hazards, collaborating to develop a crisis intervention plan, and providing adaptations for students with special needs.
- **Family and community involvement:** By taking a leadership role in collaborating with community agencies to identify and provide programs to meet the physical and mental health needs of children and families.

RATIONALE:

School nurses should assume a leadership role and collaborate with organizations, institutions and local, state and federal governments to advocate for policies, legislation, and financing for the development, implementation, and evaluation of coordinated school health programs. In particular, improving the school nurse to student ratio is a key component to ensuring that that nation's children have access to coordinated school health programs.

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Coordinated School Health Program (Adopted: June 1999, Revised: June, 2001)

Coordinated School Health Education (Adopted: June 2003)

Revised: June 2008

Corporal Punishment in the School Setting

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that corporal punishment should be legally prohibited in all states and that alternative forms of student behavior management be utilized in the school setting.

HISTORY

By definition, corporal punishment is the intentional infliction of physical pain as a method of changing behavior (NASP, 2006). Historically corporal punishment has been used to discipline school students although physical punishment is currently prohibited in public schools in 29 states, including many school districts in many major American cities (Gershoff, 2008; National Coalition to Abolish Corporal Punishment in Schools [NCACPS], 2008; United State Government Accountability Office [GAO], 2009).

The American Academy of Pediatrics (2006), the National Parent Teacher Association (2010), the National Association of School Psychologists (2006), and the American Academy of Family Physicians (2007) are among groups that have taken a position recommending the abolishment of corporal punishment.

DESCRIPTION OF ISSUE

Corporal punishment adversely affects students' self-image and school achievement, can contribute to disruptive behaviors, can result in physical harm, inhibits the development of appropriate social skills, and also promotes the message that violence is an acceptable mode of behavior in our schools (National Association of School Psychologists [NASP], 2006).

RATIONALE

There is little research that supports the premise that physical punishment will change the behavior of children and youth. The school nurse, as an advocate for the health and well-being of students, must take the position that corporal punishment places students at risk for negative outcomes, including increased aggression, antisocial behavior, mental health problems and physical injury (Gershoff, 2008). A multi-faceted approach to student behavior management is needed including strategies that support parents and teachers, and strategies that alter the school or classroom environments (NASP, 2006).

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SUMMARY

It is the position of the National Association of School Nurses (NASN) that the delegation of nursing tasks in the school setting can be a valuable tool for the school nurse, when based on the nursing definition of delegation and in compliance with state nursing regulations and guidance.

Delegation in school nursing is a complex process in which the authority to perform a selected nursing task is transferred to a competent unlicensed individual (UAP) in a specific situation. The decision to delegate and the supervision of delegation of nursing tasks in the school setting rest solely with the registered nurse, who makes the determination to delegate based on nursing assessment and in compliance with applicable laws and guidance provided by professional nursing associations (American Nurses Association [ANA]/National Council of State Boards of Nursing [NCSBN], 2006; *Mitts vs. Hillsboro Union High School*, 1987)

The safety and welfare of the individual student and the broader school community must be the central focus of all decisions regarding the delegation of nursing tasks and functions (ANA/NCBSN, 2006). Delegation is used effectively in some areas, but unsafe and illegal delegation in school settings can occur. It is important for school districts, registered nurses, health care professionals, parents and the public to understand what activities can be delegated and when delegation is appropriate. Delegation *may* occur when the registered nurse determines it is appropriate to provide necessary treatment, but such delegation *may not* be appropriate for all students or all school nursing practices. The legal parameters for nursing delegation are defined by State Nurse Practice Acts, State Board of Nursing guidelines, and Nursing Administrative Rules/Regulations (NCSBN, 2005). Delegation of nursing tasks is not allowed in some states.

HISTORY

Delegation is a valuable tool in meeting the health care needs of school children. Federal laws set requirements for the provision of health care to children in schools. Laws such as the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990 ensure that children with special health care needs have the right to be educated with their peers in the least restrictive environment (Section 504 Rehabilitation Act, 1973) and to receive support and accommodations for conditions that adversely impact their capacity for learning. (Gelfman, 2001) School nurses can use their expert assessment skills to appropriately delegate health-related tasks and meet the specific health care needs of students, increasing access to a free appropriate public education. (Resha, 2010)

Advances in health care and technology offer greater opportunities for children with special health care needs to attend school, bringing medically fragile students into the general school population. The incidence of chronic conditions such as asthma, diabetes, severe allergies, and seizure disorders in school-age children is increasing; and complex medical problems that were previously handled in acute care settings are now being managed in the school setting, requiring registered nurses to make care decisions that may include delegation where appropriate.

DESCRIPTION OF ISSUE

The term delegation is used in other fields, but has a unique place and meaning in the practice of nursing. Delegation of nursing care is a legal term and a complex skill requiring sophisticated clinical judgment and final

accountability for care of the client (NCBSN, 2005). Effective delegation in school nursing practice requires a registered nurse who has the requisite skill, expertise and authority to practice in the state in which the delegation occurs.

ANA defines nursing delegation as *transferring the responsibility of performing a nursing activity to another person while retaining accountability for the outcome* (ANA/NCSBN, 2006); National Association of State School Nurse Consultants [NASSNC], 2010). Nurses are accountable to: (1) state laws, rules, and regulations; (2) employer/agency regulations, and (3) standards of professional school nursing practice, including those pertaining to delegation. The decision to delegate is a serious responsibility that the registered nurse determines on a case-by-case basis based on the needs and condition of the student, stability and acuity of the student's condition, potential for harm, complexity of the task, and predictability of the outcome (ANA, 2005). Prior to delegation, a student assessment is required to guide the school nurse in determining the level of training and supervision required for safe delegation for this specific student and assignment.

Nursing tasks commonly performed in the home setting by a parent/guardian or caregiver take on a more complex dimension in the school setting. Often parents and school administrators are confused about why what appears to be a simple task is held to a much different and higher standard at school (NASN, 2005). The school nurse practices in the educational setting where nurses support the primary purpose of providing education and must consider meeting federal mandates, nursing licensure standards and parental expectations when working to ensure the health and safety of all students.

Supervision of delegated nursing tasks means the delegating registered nurse must periodically monitor and assess the capabilities and competencies of the licensed practical nurse or unlicensed personnel to safely perform delegated tasks. Only the registered nurse determines how closely and often an unlicensed individual must be supervised and reassessed. If an individual who has been assigned by a school administrator is not suitable for the task, whether it is due to lack of education, attentiveness, availability or proximity, the registered nurse must work with administration to locate a better suited individual. The registered nurse adheres to the state nurse practice act and standards of nursing practice, even if it conflicts with an administrator's directives.

RATIONALE

The appropriate professional to delegate nursing tasks is the registered professional nurse. Delegation is not appropriate for all students, all nursing tasks, or all school nurse practices. The American Nurses Association (2005) does not support nurses delegating steps in the nursing process, including nursing assessment or the use of nursing judgment (ANA/NCBSN, 2006). Key factors guiding determination for delegation include the following: state laws, rules, and regulations; safety issues; medical needs of students; school practice characteristics; and UAP competence.

To provide for safe care, nurses can utilize the Five Rights of Delegation (ANA/NCSBN, 2006) to guide their assessment of whether delegation is appropriate for the student and the situation.

1. The Right Task
2. The Right Person
3. The Right Direction
4. The Right Supervision
5. The Right Circumstance

When a review of the Five Rights of Delegation indicates that delegation is appropriate, the school nurse must develop an individualized healthcare plan (IHP) outlining the level of care and health care interventions needed by

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the student and indicating which tasks can and cannot be delegated. Further, the continuous process of evaluation should be based on outcomes of care, ensuring that the delegated task is completed properly and produces the desired outcome.

Additional tools available to the school nurse when determining if delegation is appropriate include the American Nurses Association's *Principles of Delegation* and the National Council of State Boards of Nursing *Decision Tree - Delegation to Nursing Assistive Personnel* (ANA/NCSBN, 2006).

American Nurses Association ■ Principles for Delegation

Overarching Principles:

- The nursing profession determines the scope of nursing practice.
- The nursing profession defines and supervises the education, training and utilization for any assistant roles involved in providing direct patient care.
- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN accepts aid from nursing assistive personnel in providing direct patient care.

Nurse-related Principles:

- The RN may delegate elements of care but does not delegate the nursing process itself.
- The RN has the duty to answer for personal actions relating to the nursing process.
- The RN takes into account the knowledge and skills of any individual to whom the RN may delegate elements of care.
- The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence experience and facility/agency policies and procedures.
- The RN acknowledges that there is a relational aspect to delegation and that communication is culturally appropriate and the person receiving the communication is treated respectfully.
- Chief nursing officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation, both for RNs and delegates.
- RNs monitor organizational policies, procedures and position descriptions to ensure there is no violation of the Nurse Practice Act, working with the state board of nursing if necessary.

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Adopted: 2006
Revised: 2010

Diabetes Management in the School Setting



Position Statement

SUMMARY

It is the position of the National Association of School Nurses that the registered professional school nurse (hereinafter referred to as school nurse) is the only school staff member who has the skills, knowledge base, and statutory authority to fully meet the healthcare needs of students with diabetes in the school setting. Diabetes management in children and adolescents requires complex daily management skills (American Association of Diabetes Educators [AADE], 2008) and health services must be provided to students with diabetes to ensure their safety in the school setting and to meet requirements of federal laws.

HISTORY

For children and youth younger than 20 years, diabetes is on the rise with an estimated 215,000 children and adolescents with type 1 or type 2, or approximately 0.26% of this age group. Annually, from 2002 to 2005 -- 15,600 youth were newly diagnosed with type 1 diabetes and 3,600 youth were newly diagnosed with type 2 diabetes (Centers for Disease Control and Prevention [CDC], 2011).

Advancing diabetes technology and management have changed the way students manage their diabetes at school. Children are monitoring their blood glucose levels several times a day, calculating carbohydrate content of meals, and dosing insulin via syringe, pen and pump to achieve a blood glucose within a target range (Bobo, Kaup, McCarty & Carlson, 2011). These intensive resources and consistent evidenced-based efforts will achieve the long-term health benefits of optimal diabetes control according to the landmark study from the Diabetes Control and Complications Trial Research Group (DCCT, 1996).

DESCRIPTION OF THE ISSUE

Each student with diabetes is unique in his or her disease process, developmental and intellectual abilities and levels of assistance required for disease management. The goals of the Diabetes Medical Management Plan (DMMP) and Individual Health Plan (IHP) are to promote normal or near normal blood glucose with minimal episodes of hypoglycemia or hyperglycemia, normal growth and development, positive mental health, and academic success (Kaufman, 2009).

The school nurse develops the IHP from the DMMP (medical orders) by collaborating with the child's family, obtaining additional assessment findings, and outlining the diabetes management strategies and personnel needed to meet the student's health goals in school (NDEP, 2010). The IHP identifies the student's daily needs and management strategies for that student while in the school setting. The school nurse also coordinates the development and staff education of the Emergency Care Plan (ECP) which directs the actions to be taken by school personnel for symptoms of hypoglycemia and hyperglycemia.

Throughout childhood and adolescence, the student with diabetes is continuously moving through transitions toward more independence and self-management (Silverstein et al., 2005). They will require various levels of supervision or assistance to perform diabetes care tasks in school. Students who lack diabetes management experience or cognitive and developmental skills must have assistance with their diabetes management during the school day as determined by the nursing assessment and as outlined in the IHP.

Hypoglycemia (low blood glucose) is the greatest immediate danger to the student with diabetes. During hypoglycemic incidents, the student may not be able to self-manage due to impaired cognitive and motor function. A student experiencing hypoglycemia should never be left alone or sent anywhere alone. Communication systems and trained school staff should be in place to assist the student. Treatment for hypoglycemia should be readily available in the classroom and administered immediately (American Diabetes Association [ADA], 2011).

Hyperglycemia (high blood glucose) can develop over several hours or days, and untreated can lead to the life-threatening condition, diabetic ketoacidosis (DKA). For students using insulin infusion pumps, lack of insulin may rapidly lead to DKA (ADA, 2011). The school nurse may utilize one or more of the model National Diabetes Education Program's (NDEP) three levels of staff training, to facilitate prompt, safe and appropriate care for students with diabetes (NDEP, 2010).

Students with disabilities, which include students with diabetes, must be given an equal opportunity to participate in academic, nonacademic, and extracurricular activities. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 prohibit recipients of federal financial assistance from discriminating against people on the basis of disability (NDEP, 2010). These laws are enforced for schools, by the Office for Civil Rights (OCR) in the U.S. Department of Education. Schools are required to identify all students with disabilities and to provide them with a free appropriate public education (FAPE) (NDEP, 2010).

Changes in science and technology related to diabetes management require the school nurse to maintain current knowledge and skills to fully implement a student's DMMP in the school setting (NDEP, 2010; ADA, 2011).

RATIONALE

Managing diabetes at school is most effective when there is a partnership among students, parents, school nurse, health care providers, teachers, counselors, coaches, transportation, food service employees, and administrators. The school nurse provides the health expertise and coordination needed to ensure cooperation from all partners in assisting the student toward self-management of diabetes.

A school nurse is required to develop an IHP for each student with diabetes and to provide continued oversight for the implementation and evaluation of the effectiveness of the plan in the school setting (American Nurses Association /National Association of School Nurses [ANA/NASN], 2011). Individualized healthcare planning is a function of the nursing process and cannot be delegated to unlicensed individuals (American Nurses Association / National Council of State Boards of Nursing Association of School Nurses [ANA/NCSBN], 2006). State laws and nurse practice acts determine the extent to which school nurses can delegate nursing tasks to other school personnel in the absence of the nurse (ANA/ NASN, 2011).

Research suggests that school nurse supervision of students' blood glucose monitoring and insulin dose adjustment significantly improves blood glucose control in children with poorly controlled type 1 diabetes (Nguyen et al., 2008). Poorly controlled diabetes and fluctuating blood glucose levels not only affect academic performance but can lead to long-term complications such as retinopathy, cardiovascular disease, and nephropathy. Maintaining blood glucose levels within a target range can prevent, reduce, and reverse long-term complications of diabetes (DDCT, 1996).

The school nurse's role is critical in the case management and coordination of care for recognition and treatment of the student experiencing hypoglycemia in school (Butler, 2007). The school nurse fosters independent decision making, promotes healthy life-style choices and diabetes self-care ensuring a smooth transition between high school and adult diabetes medical care (Bobo & Butler, 2010). Every student with diabetes is entitled to a school nurse with the knowledge and capacity to effectively provide care and communicate with school staff, healthcare providers and families (Bobo et al., 2011).

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Adopted: January 2012

This document combines and replaces the following Position Statements:

Blood Sugar Monitoring in the School Setting (Adopted: June 2001)

School Nurse Role in Care and Management of the Child with Diabetes (Adopted: November 2001; Revised: June 2006)

Education, Licensure, and Certification of School Nurses



Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that every school-age child deserves a school nurse who has a baccalaureate degree in nursing from an accredited college or university and is licensed as a registered nurse through the State Board of Nursing. These requirements constitute minimal preparation needed to practice at the entry level of school nursing (American Nurses Association [ANA] & National Association of School Nurses [NASN], 2011). Additionally, NASN supports state school nurse certification, where required, and promotes national certification of school nurses through the National Board for Certification of School Nurses (NBCSN).

HISTORY

Expectations for preparation of the registered professional school nurse (hereinafter referred to as school nurse) have evolved within the context of the larger nursing profession. In 1920, the Goldmark Report, funded by the Rockefeller Foundation, proposed educating nurses in academic institutions, arguing that this would more adequately prepare nurses to meet the needs of society (Ellis & Hartley, 2008). Baccalaureate nursing education develops better skills in leadership and critical thinking, the ability to translate research into nursing practice, and knowledge of population health, important skills not addressed in an associate degree nursing (ADN) education (National Advisory Council on Nurse Education and Practice [NACNEP] 2010; Ellenbecker, 2010).

To practice as a professional registered nurse, graduates must take and pass the state licensure exam. In addition to nursing licensure by a state Board of Nursing, some states require additional post-baccalaureate education and certification approved by state departments of education to practice school nursing. Requirements for state certification and the certifying bodies vary by individual state (Costante, 2006). Licensure documents a minimal level of knowledge to safely practice basic nursing, and certification documents a higher level of competence and expertise in a focused area of practice. In the 1980's, NASN developed a national certification examination and then established the National Board for Certification of School Nurses (NBCSN), which became an independent incorporated body in 1991. The purpose was twofold: to promote and recognize quality practice in school nursing and to assure that certification criteria and examinations in school nursing are determined by experts in the specialty practice.

DESCRIPTION OF ISSUE

The American Nurses Association (ANA) takes the position that the minimum preparation for beginning *professional* nursing practice should be a baccalaureate degree and the minimum preparation for technical nursing practice is an associate degree (ANA, 2011). A number of other organizations including the Carnegie Foundation for the Advancement of Teaching, American Association of Colleges of Nursing, the Pew Health Professions Commission and the NACNEP support the baccalaureate degree as an entry level for *professional* nursing (Benner, Sutphen, Leonard & Day, 2009; Smith, 2009; NACNEP, 2010).

School nursing requires advanced skills that include the ability to practice independently, supervise others, and delegate care in a community, rather than a hospital or clinic setting (ANA & NASN, 2011).

RATIONALE

As a specialty practice, school nursing requires advanced skills to address the complex health needs of students within a school community setting (NASN/ANA, 2011). These skills are attained through a baccalaureate degree in nursing as well as specialized certification in school nursing (Institute of Medicine (IOM), 2011). Specialty certification for nurses with a BSN or higher education improves patient outcomes and baccalaureate-educated

nurses with specialty certification have the potential to improve the quality of care. (Kendall-Gallagher, Aiken, Sloane, Douglas & Cimiott, 2011).

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Emergency Preparedness –

The Role of the School Nurse

Position Statement



SUMMARY

It is the position of the National Association of School Nurses (NASN) that school nurses provide leadership in all phases of emergency preparedness and management and are a vital part of the school team that develops emergency response procedures for the school setting, using an all-hazards approach.

HISTORY

Until recent years, disaster planning in schools encompassed primarily fire and severe weather drills. The concept of school emergency, or crisis, eventually took on an expanded meaning to include all dangerous events that normally can be managed at a local level (Doyle and Loyacono, 2007). Incidents or crises cannot always be controlled and vary in scope, intensity, impact, and location. Furthermore, it has been recognized that a crisis could occur before, during or after school, and each school is unique with its own needs, resources, and assets (Cole, Tyson, Fitzgerald, Hopkins, 2007).

Recognizing that nearly 49.4 million students attend public elementary and secondary schools and an additional 5.8 million students attend private schools on a daily basis (National Council for Education Statistics [NCES], 2010), NASN developed Continuing Nurse Education *disaster preparedness training programs* and carries the *Disaster Preparedness Guidelines for School Nurses* in its bookstore. In addition, NASN was instrumental in the delivery of a U.S. Department of Education Webinar on disaster preparedness. On any given day, schools accommodate a significant proportion of a community's population and have an obligation to be able to care for students and staff, as well as community members, in the event of an emergency. The U.S. Department of Homeland Security developed the National Incident Management System/Incident Command System (NIMS/ICS) to provide an operational framework that enables responders from various organizational levels and agencies to work together consistently and comprehensively to plan for, respond to, and recover from incidents (Cole, Tyson, Fitzgerald, Hopkins, 2007).

DESCRIPTION OF ISSUE

School nurses are the link to local public health departments (Fitzpatrick, 2006) and emergency services, and it is imperative that school nurses be familiar with this standardized common language provided through the federal government agencies. They serve as conduits for dissemination of public health information to students and families and liaison with emergency medical services to plan for a potential mass casualty event and provide care for students in the event of emergency illness or injury.

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Children spend a large part of their day in schools; therefore, the school district plays an important role during a large-scale crisis. Schools are generally considered safe havens for children, but various types of emergencies can occur within the school walls or beyond, impacting the school and/or surrounding community. Natural disasters and pandemic illness, as well as physical plant or technological hazards, may cause damage in the school ranging from loss of power to major structural damage and result in physical injuries, including loss of life.

Doyle and Loyacono (2007) state that nurses, by virtue of their professional education, are experts in the nursing process (assess, plan, implement, and evaluate), and the steps taken during emergency situations closely parallel the phases of emergency management (prevention/mitigation, preparedness, response, and recovery). The school nurse is in a leadership position to provide continuous integration, coordination, and training of all school and community members as a part of the school's emergency management plan. The role of the school nurse within the four identified phases of emergency management planning includes the following:

Prevention/ Mitigation: School nurse assistance is appropriate in an on-going assessment to identify hazards from all possible sources and to reduce the potential for an emergency to occur. Examples include establishing and conducting school safety programs, participating in school committees, implementing vaccination programs and educating students and staff about recognizing and reporting suspicious events (Doyle and Loyacono, 2007).

Preparedness: School nurse service on community-wide planning groups is helpful in the facilitation of a rapid, coordinated, effective emergency response within the framework of the Incident Command System. This includes establishing standard emergency response plans and participating in skills, drills and exercises to evaluate the response capabilities of a school, as well as the effectiveness of the plan (e.g., evacuation, shelter-in-place, lock down, intruder). Specifically, the school nurse can be instrumental in identifying unique emergency preparedness needs for children with special needs.

Response: It is critical that the school nurse be knowledgeable about his or her role in the emergency plan. This includes triage, coordination of the first aid response team, and direct hands-on care to victims of the emergency. In addition to providing mental health support to students, the school nurse is an important link to the medical/public health community and to parents (Fitzpatrick, 2006).

Recovery: After a disaster, the school nurse assists with students, parents, and school personnel, providing direct support and being the liaison between community resources and those in need. The school nurse provides a unique perspective when involved in the evaluation and revision of school emergency plans. Schools may be identified as an emergency shelter resource for the community at large and/or a primary location for the community either to gather to volunteer services or to reunite families.

RATIONALE

School nurses are strategically placed within school environments and can identify potential emergencies and assist in planning a comprehensive and coordinated response. As licensed health care professionals,

they respond to all serious adverse events that threaten the health, safety, or well-being of a school population. School nurses, as advocates for school safety, must address new challenges in emergency management and response (American Academy of Pediatrics [AAP], 2008) and establish their vital role before, during, and after an emergency, addressing the needs of all members of the school community, including children with special health care needs.

Schools must address emergencies that can vary from a single student injured on a playground, possibly sustaining a fall from a height with a suspected head or spinal cord injury, to the mass illness situations seen with the H1N1 pandemic flu. School nurses deal with weather-related emergencies, and the nature of these emergencies often depends on geographic location. They can range from hurricanes, tornadoes, tsunamis and flooding to snow and ice storms. If students are required to be sheltered in school for long periods of time, this creates issues for students with chronic health conditions, including diabetes, asthma, and allergies/anaphylaxis. Dramatic large scale emergencies occur in the school as well as many well publicized violent events, such as school shootings that create serious safety and injury issues. Schools can also be vulnerable to explosions and fires. In addition, schools located near nuclear power plants have their own concerns about potential accidents and emergencies.

The school nurse is a vital school professional who is knowledgeable of the physical and emotional needs of the students served by the school (Fitzpatrick, 2006). It is important for the school team to include a school nurse on its crisis team to optimize positive outcomes in all phases of emergency management. School administrators should ensure that the school nurse pursue professional development, as needed, to address skills related to emergencies with an emphasis on planning, performing triage, providing emergency care and promoting a positive recovery phase for the school and community.

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This document combines and replaces the following Position Statements:

Disaster Preparedness the Role of the School Nurse (Adopted: June 2001; Revised: June 2006)

Bioterrorism Emergency Preparedness and Response, School Nurse Role (Adopted: June 2002;
Revised: June 2005)

Chemical and Radiological Threats, Role of the School Nurse in Emergency Preparedness (Adopted: June
2002; Revised: June 2005)

SUMMARY

The National Association of School Nurses supports health care reform legislation passed in 2010 in the form of the Patient Protection and Affordable Health Care Act, PL 111-14. This legal framework for health care addresses some of the documented needs and goals pertinent to the healthcare of our nation's school students.

HISTORY

Since 1978, the World Health Organization articulated its challenge to all nations to provide a basic level of health care to its citizens, this was reaffirmed as late as 2007. In 2009, the American Nurses Association stated that the current fragmented and costly U.S. health care system is in a state of crisis and stands as evidence of the futility of patchwork approaches to health system reform. (American Nurses Association [ANA], 2010). The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health care coverage to low-income children not eligible for Medicaid coverage. In 2009, Congress enacted, and President Barack Obama signed, legislation that renewed CHIP through the end of 2013 as well as expanded its scope (Sullivan, 2009).

DESCRIPTION OF ISSUE

The Centers for Disease Control and Prevention report that the percentage of children without health insurance was 8.9% in 2008. While this is significantly lower than numbers reported in 1997, it represents an exceptional number of children who do not have health insurance (Centers for Disease Control and Prevention [CDC], 2009).

The health reform legislation passed in 2010 addresses quality, affordable health care for all children, lower costs to cover children, and greater choices to meet the health care needs of children.

The school nurse is in a strategic position as a healthcare professional to advocate for and facilitate access to healthcare for students and their families. National objectives pertinent to improving the health status of our nation's students are achievable through the united efforts of all vested partners. "Access to Quality Health Services" is one of ten leading health indicators of Healthy People 2010 and continues as a proposed objective in Healthy People 2020 (U.S. Department of Health and Human Services, 2000). These indicators and objectives are important in the work of school nurses as they address the health concerns of our nation's youth (Praeger, 2006).

RATIONALE

School nursing is a specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. There is a role for school nursing in implementing the provisions of the recent healthcare reform law.

The passage of this new legislation is a significant investment in the health of our nation's students and school nurses stand ready to work with pediatricians and other health professionals in efforts to improve

the health care access, benefits, and coverage of students in the United States, especially those most in need of care. The National Association of School Nurses supports quality affordable health care for all children and believes school nurses are knowledgeable professionals who can assist students and their families in accessing appropriate health insurance and necessary healthcare services as well as provide vital health services to students.

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SUMMARY

It is the position of the National Association of School Nurses (NASN) that immunizations are a key to primary prevention of disease from infancy through adulthood. The school nurse is in a critical position to create awareness and influence action related to mandated and recommended immunizations in the school community. The school nurse can also provide leadership in the development of school-located immunization programs.

NASN supports the Centers for Disease Control and Prevention (CDC) recommended vaccines; and federal, state, and local legislation that provides for the immunization of students and their families. In addition, NASN supports local and state policy that ensures reimbursement to schools that choose to provide immunizations to students.

NASN also supports the development of an immunization registry in each state. "Immunization registries are confidential, population-based, computerized information systems that collect vaccination data about all children within a geographic area" (CDC, 2009a). By providing complete and accurate information on which to base vaccination decisions, registries are key tools to increase and sustain high immunization rates.

HISTORY

Vaccination against childhood diseases is one of the greatest public health achievements of the last half century. Since 1900, substantial achievements have been made in the control of many vaccine-preventable diseases in the United States with many diseases either eradicated or greatly reduced in incidence. The American Academy of Pediatrics offered the first immunization guidelines in the 1930s (CDC, 2007). National efforts to promote immunizations among all children began in 1955 with the appropriations of federal funds for polio vaccinations.

All states require immunizations prior to entry into school with additional vaccines required during the school age years. Though regulations are similar, they often vary among states. With the advent of new vaccines, recommendations and school requirements are likely to change. Despite significant levels of vaccine compliance, segments of the public continue to voice concerns about potential adverse effects of vaccines. These concerns potentially threaten vaccine uptake, and place added burden on the medical and public health communities (Cooper, 2008; CDC, 2010).

DESCRIPTION OF ISSUE

Vaccines are responsible for the control and elimination of many infectious diseases that were once common in the United States. With new vaccines, combination vaccines, and the expansion of childhood, adolescent and adult immunization schedules -- the capacity to prevent infectious disease has markedly increased since 2002 (Pickering et. al., 2009). However, the viruses and bacteria that cause vaccine-preventable disease and death still exist and pose a risk for unvaccinated people. In addition, vaccine-preventable diseases have a costly impact on Americans, resulting in lost work time for parents, additional doctor's visits, hospitalizations, and premature deaths.

Access to reputable vaccine information is an issue of growing importance. Society is mobile, with families relocating and needing to access their child's immunization information. Healthcare providers often have an incomplete record from the parent or previous provider, creating a need for a centralized immunization registry at the state and national level. Natural disasters, such as flooding, have destroyed students' records, both at their school and their healthcare provider's offices.

Immunization registries provide official, accurate records for the private provider, families, and schools. Registry data can also be used to target community immunization programs (CDC, 2009b).

RATIONALE

To realize the full benefit of immunizations, individuals must recognize that vaccines are a safe and effective way to help the body defend against vaccine-preventable diseases. Healthcare providers, including the school nurse, are in a position to maintain and share current knowledge and recommendations regarding vaccines with the communities they serve.

To optimally prevent disease, disability, and death from vaccine preventable illnesses, the vaccine delivery system must target children, adolescents and adults. Professional school nurses practice in an ideal setting to educate families and staff regarding the indications, contraindications, side effects, and timeliness of initial and booster doses of immunizing agents.

As the primary health professional in schools, professional school nurses are responsible for coordinating school and public health immunization programs and have opportunities to counsel families and staff regarding immunizations throughout the lifespan. In collaboration with local public health groups, schools can be an effective location for the delivery of vaccines to children, particularly in areas where the population is under-immunized. NASN supports the position that schools should seek third-party reimbursement for these vital health services.

Immunization registries are important tools for school nurses and others to utilize to facilitate immunization compliance; they help school nurses identify fully immunized students as well as children that are at risk in the event of a disease outbreak (AAP, 2006). Immunization registries help prevent duplication of vaccinations when records have been lost, destroyed or misplaced.

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National Association of School Nurses

Position Statement *Individualized Healthcare Plans (IHP)*

SUMMARY OF THE POSITION:

It is the position of the National Association of School Nurses (NASN) that students whose healthcare needs affect or have the potential to affect safe and optimal school attendance and academic performance require the professional school nurse to write an Individualized Healthcare Plan (IHP), in collaboration with the student, family, educators, and healthcare care providers. It is also the position of NASN that it is the responsibility of the professional school nurse to implement and evaluate the IHP at least yearly to determine the need for revision and evidence of desired student outcomes.

HISTORY:

The IHP is a written document that outlines the provision of student healthcare services intended to achieve specific student outcomes. The management of school healthcare services for students with significant or chronic health problems is a vital role for school nurses (National Association of School Nurses [NASN] & American Nurses Association [ANA], 2005). The standard for this role is based on the nursing process and must include: Assessment, Nursing Diagnosis, Outcome Identification, Planning, Implementation, and Evaluation. Documentation of these steps for individual students who have healthcare issues results in the development of Individualized Healthcare Plans (IHPs), a variation of nursing care plans. IHPs fulfill administrative and clinical purposes including management of healthcare conditions to promote learning; facilitating communication, coordination, and continuity of care among service providers; and evaluation/revision of care provided (Herrmann, 2005).

DESCRIPTION OF ISSUE:

Chronic mental and physical health conditions or disabilities can interfere with school participation and achievement. Many students with stable conditions, such as attention deficit-hyperactivity or mild intermittent asthma, require basic school nursing services such as health care monitoring or medication administration. Some students need specialized services and require an IHP, which may include an emergency care plan (ECP) and/or a field trip plan. The need for an IHP is based on required nursing care, not educational entitlement such as special education or Section 504 of the Rehabilitation Act of 1973.

Sometimes, students need the additional protections of federal laws in order to fully participate in an educational program. PL 93-112 Section 504 of the Rehabilitation Act of 1973 (also called Section 504) identifies criteria that indicate accommodations may be required (504 plan) for an eligible student. PL 108-446 (2004), the Individuals with Disabilities Education Improvement Act (IDEIA) entitles students who are eligible for special education to receive services that are necessary to access or benefit from their educational program. Special healthcare services are outlined in the Individual Education Plan (IEP). For special education students, the IHP may be included as an attachment to the IEP.

The nursing process “provides the framework for the delivery and evaluation of nursing care” to students (Denehy, 2004, p. 7). *The Scope and Standards of Practice* (NASN & ANA, 2005) outlines how each step of the

nursing process is implemented to strengthen and facilitate educational outcomes for students. These steps parallel components of a well-written IHP.

Standard 1. Assessment: The data collection phase helps determine the student's current health status and any actual or potential health concerns.

Standard 2. Diagnosis: The professional school nurse uses the assessment data to formulate a nursing diagnosis, including a diagnostic label, etiology, and presenting signs and symptoms.

Standard 3. Outcome Identification: The professional school nurse identifies the desired results of nursing intervention and states these in measurable terms.

Standard 4. Planning: Interventions are selected to achieve desired results.

Standard 5. Implementation: The written IHP is put into practice and care provided is documented.

Standard 6. Evaluation: The professional school nurse measures the effectiveness of nursing interventions in meeting the identified outcome. Changes are made to the plan as needed.

The school nurse must determine which students require an IHP, prioritizing those students whose healthcare needs affect their daily functioning or safety. These students may have multiple healthcare needs, require lengthy procedures or treatments, require routine or emergency contact with the school nurse or unlicensed assistive personnel during the school day, or require special healthcare services as part of their IEP or Section 504 plan.

Performance and documentation of the nursing process are professional school nursing functions that cannot be delegated (National Council of State Boards of Nursing, 2005). The registered professional school nurse is responsible and accountable for creating the individualized healthcare plan (IHP), for managing its activities, and for its outcomes, even when implementation of the plan requires delegation to unlicensed assistive personnel (NASNa, 2006).

The IHP is developed collaboratively with information from the family, the student, the student's healthcare providers, and school staff, as appropriate (NASN & ANA, 2005). The IHP includes medical orders implemented at school. Evaluation identifies progress toward achieving student outcomes. The IHP is reviewed at least annually, updated as needed, and revised as significant changes occur in the student's health status or medical treatment.

Standardized IHP's, printed or computerized, are available for common chronic pediatric health conditions. These standardized plans help promote continuity of care but individualization is essential in order to meet the unique needs of each student. In addition, NASN encourages the use of standardized language such as North American Nursing Diagnosis Association-International (NANDA), Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC) in IHP development (Denehy, 2004). Standardized language facilitates communication with other nursing staff and data collection, links student health care and education outcomes, and helps nurses evaluate correlations between interventions and outcomes (NASNb, 2006). Furthermore, the use of standardized language enhances development of a common knowledge base for school nursing which is essential for evidence-based practice (Poulton and Denehy, 2005).

RATIONALE:

Professional school nurses are leaders in the provision of special healthcare services. Through coordination of care among the school and the home, primary and specialty medical care, and clinics, school nurses ensure continuity of care across settings and minimize the risk for miscommunication (Taras et al., 2004). School nurses are also responsible for the training, direction, and supervision of both licensed and unlicensed personnel and the delegation of select nursing tasks as directed by individual state nurse practice acts (NASN & ANA, 2005). An IHP is the written document that captures these professional activities provided to individual students (Selekman, 2006).

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Infectious Disease Management in the School Setting

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that a primary role of the school nurse is the prevention and control of infectious disease. School nurses have the professional knowledge and public health perspective to provide leadership in designing and implementing programs targeting infectious diseases. Key components of school-based infectious disease programming includes the promotion of vaccines; individual and schoolwide infection control measures; and how to contain, manage and prevent further spread of infectious diseases. The school nurse also plays a role in disease surveillance and reporting, providing a vital link between the school and public health community (Association of State and Territorial Directors of Nursing, 2000).

HISTORY

In 1902, Lina Rogers, the first school nurse in the United States, demonstrated the value of school nursing when her program significantly improved the pupil attendance rate by examining and treating students with infectious disease and by instructing parents about the care of their child (Schumacher, 2002). Infectious diseases have continued to be a major contributing factor to significant childhood morbidity and mortality around the world (Mathers, Lopez & Murray, 2006). Immunizations, one of the most vital public health interventions of the 20th century, have protected children against many infectious agents (Diekema, 2005). Improved hygiene and sanitation, and the judicious use of antibiotics have also contributed to declines in morbidity and mortality throughout the 20th century (Centers for Disease Control and Prevention [CDC], 1999).

This is a challenging issue in the school setting. The aggregation of children at school increases the risk for the spread of infectious diseases. Student absences due to infectious diseases cause the loss of millions of school days each year (CDC, 2010). But the school setting also offers the opportunity for the school nurse to promote healthy behaviors and prevention strategies (Aronson & Shope, 2008).

DESCRIPTION OF ISSUE

School nurse knowledge about the epidemiology of infectious diseases provides the evidence base to direct surveillance for and intervention to control the spread of disease, as highlighted in the case of the 2009 H1N1 influenza outbreak (Garcia, Bergren, Butler, & Bobo, 2009). The school nurse role in the school is an extension of public health, creating a natural partnership with the public health community at the local and state levels enforcing laws, regulations, and policies that protect the health of the school community.

The cultural competence of the school nurse provides additional guidance on how to approach students, families and the community to engage them in strategies, (i.e. universal precautions or use of masks) to prevent and manage infectious diseases. Knowledge about the individual health needs of students and school personnel allows the school nurse to further individualize infection control strategies targeting those at most risk.

RATIONALE

School-age children are a population at risk for contracting and spreading infectious diseases due to their inconsistent use of proper hand hygiene, cough etiquette and social distancing from others who may be displaying signs and symptoms of infection. Local and global communities must deal with on-going emerging and resurging infectious diseases that continue to threaten the well-being of children and youth. School nurses are highly qualified to identify symptomatic trends, prevent and manage infectious disease in the school setting, and access and interpret public health information.

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Medication Administration in the School Setting

Position Statement



SUMMARY

It is the position of the National Association of School Nurses (NASN) that school districts develop written medication administration policies and procedures that focus on safe and efficient medication administration at school by a registered professional school nurse (hereinafter referred to as school nurse). Policies should include prescription and non-prescription medications, and address alternative, emergency, research medication, controlled substances, and medication doses that exceed manufacturer's guidelines. These policies shall be consistent with federal and state laws, nursing practice standards and established safe practices in accordance with evidence based information. The *Individuals with Disabilities Education Act, and Section 504*, mandate schools receiving federal funding to provide "required related service", including medication administration (O'Dell, O'Hara, Kiel, & McCullough, 2007).

HISTORY

Medication administration to students is one of the most common health-related activities performed in school. Historically, administering medication within the school setting has been a school nurse responsibility. As more chronically ill, medically stable children enter the school system each year, awareness of the factors that can promote and support their academic success increases, including the need for medications that enhance the student's overall health or stabilize their chronic condition.

DESCRIPTION OF ISSUE

There has been a dramatic increase in the range of medications used in schools, making the medication administration process in school more complex, not less (McCarthy, Kelly, Johnson, Roman, & Zimmerman, 2006). Medication non-adherence at school has been linked to a variety of poor educational, social/emotional and physical outcomes. In addition, non-adherence to medication treatment regimes can lead to an array of educational, behavioral, and academic consequences for a child with chronic health conditions (Clay, Farris, McCarthy, Kelly, & Howard, 2008).

Policies regarding administration or carrying of any medication or product should be applied consistently with all students. The school nurse should assess each request for administration or student self-administration of any medication based on school district medication policies.

The school nurse can administer medication safely and effectively while adhering to the following set of guidelines that include:

- Adherence to school district specific medication handling and administration procedures/policies, national school nurse standards of practice, state nurse practice acts and state laws governing these practices.
- The administration of a specific medication is in accordance with existing State Board of Nursing rules and regulations, school district policies, school nursing protocols or standing orders.
- District policies must address how over-the-counter (OTC) medications are received, stored, and labeled.
- Procedures must be established and periodically reviewed for receiving, storing, administering, clarifying prescriptive orders, determining the prescribed dosage is within the safe dose range for the child's age and weight and accounting for all medications held or administered in the school setting.
- District policies must require parental consent for exchange of information between the school nurse and prescriber for clarification of administration and report of response to medication and adverse effects.

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- Student confidentiality is maintained in all written and verbal communications, in accordance with FERPA regulations.
- Specific issues and procedures are addressed on a district-by-district basis including medication errors, missed doses, transportation concerns and monitoring unlicensed assistive personnel (UAP) administration.

Medication administration policies and procedures should also address the following:

Delegation

In some states, medication administration can be delegated to licensed practical nurses and UAP. Delegation by nurses is defined by the American Nurses Association (ANA) as “transferring the responsibility of performing a nursing activity to another person while retaining accountability for the outcome” (ANA/NCSBN, 2006; National Association of State School Nurse Consultants [NASSNC], 2010).

Nurses remain accountable to:

- State laws, rules, and regulations;
- Employer/agency regulations, and
- Standards of professional school nursing practice, including those pertaining to delegation.

The decision to delegate is a serious responsibility that the school nurse determines on a case-by-case basis based on the needs and condition of the student, stability and acuity of the student’s condition, potential for harm, complexity of the task, and predictability of the outcome (ANA, 2005). Prior to medication administration, a student assessment is completed by the school nurse. This assessment will guide the school nurse in determining if the task can be delegated and what level of training and supervision is required for safe delegation for this specific student and assignment (Gursky & Ryser, 2007). In most circumstances, a UAP is an ancillary health office staff member (health assistant/aide) who is trained in basic first aid, selected medical procedures as indicated by the needs of the school and the students served, in addition to the district health office clerical and confidentiality procedures (AAP, 2009). An audit completed by Canham, et al. (2007), highlights the importance of training in medication administration by stating that training is not a once-a-year event, but a process that is needed to ensure and sustain the safe and accurate administration of medication.

Alternative Medication

The National Center for Complementary and Alternative Medicine (NCCAM) defines Complimentary and Alternative Medicine (CAM) as “group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.” (NCCAM, 2011). Medication administration policies should reflect local and state policies related to the administration of alternative medications and treatments.

Controlled Substances

Pharmaceutical controlled substances are drugs that have a legitimate medical purpose, coupled with a potential for abuse and psychological and physical dependence. They include opiates, stimulants, depressants, hallucinogens, and anabolic steroids. The safe and effective use of controlled substances by students at school has increased dramatically because of their accepted use in treatment of illness and disability enabling many sick and disabled children to attend school.

Emergency Medication

Immediate access to emergency medication is a high priority and is crucial to the effectiveness of these life-saving interventions (AAP, 2009). The administration of emergency medications, like all medications, is regulated by state laws and guidelines as well as local school district policies and protocols. Students with medical orders for life-saving medications should have a nursing assessment, and an Emergency Care Plan, developed by the school nurse.

Research Medication

Medication prescriptions for children that do not fall within the established United States Food and Drug Administration (FDA) guidelines for pediatric use and/or dosing may fall into two categories: off-label medication and experimental medications. Off label medications are those FDA approved medications prescribed for non-approved indications in children. Pediatric experimental or investigational drugs are those medications currently involved in clinical trials. These medications are undergoing formal study to determine the efficacy and safety of pediatric dosing, but they do not have FDA approval.

Medication administration policies should address the specific requirements for administering research medication in school, including providing the school nurse with information regarding the protocol or a study summary from the research organization, signed parental permission, reporting requirements, and any follow-up nursing actions to be taken.

RATIONALE

School nurses are in a position to influence the development and use of school medication policies. They are a valuable resource and should be utilized in the development of school district policies/procedures and consult on the creation of legislative policies relating to medication administration in the school setting (Canham et al., 2007). The school nurse is often the sole healthcare provider in the school setting, providing an expertise in health related care for students. A school nurse is the professional that has the knowledge and skills required for delivery of medication, the clinical knowledge and understanding of the student's health and the responsibility to protect the health and safety of students (AAP, 2009).

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This document combines and replaces the following Position Statements:

Alternative Medication in the School Setting (Adopted: June 2001; Revised: June 2006)

Controlled Substances in the School Setting (Adopted: November 2001)

Rectal Medication for Seizures, The Role of the School Nurse Caring for Students Requiring (Adopted: November 2003)

Research Medications in the School Setting (Adopted; June 2001)

Resources for supporting information:

NASN's Position Statement on Delegation, 2010 and AAP Clinical Guidelines for Medication Administration, 2009
Non Patient Specific Epinephrine, 2011



National Association of School Nurses

Position Statement *Mental Health of Students*

SUMMARY OF THE POSITION:

It is the position of the National Association of School Nurses (NASN) that mental health is as critical to academic success as physical well-being. School nurses play a vital role in the school community by promoting positive mental health development in students through school/community-based programs and curricula. As members of interdisciplinary teams, school nurses play a vital role in supporting early assessment, planning, intervention, and follow-up of children in need of mental health services. In addition, school nurses serve as advocates, facilitators and counselors of mental health services both within the school environment and in the community.

HISTORY:

Mental health is determined by the inter-relationship of physical, environmental, social and psychological factors and is an integral part of every child's healthy development. An imbalance between one or more of these factors can lead to a child who experiences mental health issues that interfere with the child's ability to successfully complete his/her development into a healthy productive adult. Issues that children encounter that can create an imbalance include peer bullying, victimization, youth violence, homicide, suicide, child abuse including sexual abuse and/or neglect, substance abuse, family violence, mental illness, and barriers to mental health care.

DESCRIPTION OF ISSUE:

Mental health issues refer to a myriad of health problems that interfere with student success. Good health and a good education are closely linked, and education is one of the strongest predictors of health (Freudenberg & Ruglis, 2007). Untreated mental health disorders in youth lead to increased rates of juvenile incarcerations, school drop out, and substance abuse (American Academy of Pediatrics [AAP], 2004). According to the American Academy of Pediatrics more than 14 million children and adolescents in the United States have a diagnosable mental health disorder that causes impairment in functioning. Mental health disorders that students experience include autism spectrum disorders, anxiety disorders, conduct disorders, depression, bipolar disorder, disordered eating, attention deficit hyperactive disorders, and substance abuse. It is estimated that only one-third of adolescents with a mental health disorder receives needed services (Patton, Hettrick, & McGorry, 2007).

Homicide and suicide are the fourth and fifth leading causes of death among children aged 5-14 and the second and third leading causes of death among people aged 15-24 years (Centers for Disease Control and Prevention [CDC], 2007). Ninety percent of suicides have a diagnosable mental illness at the time of the suicide, with depression being the most common.

Depression affects 8.5% of teens and 2.5% of children (Davis, 2005). As with many mental health diagnoses, co-morbidity is a significant factor in depression affecting approximately two-thirds of children and adolescents (Barcalow, 2006; Davis, 2005; DeSocio & Hootman, 2004; Woodard, 2006).

Substance abuse and/or peer or Internet bullying have been implicated in both school homicides and suicides. Children in grades 6 through 10 indicate that approximately 29.9% of them are bullied moderately or frequently (Raskauskas & Stoltz, 2004). Bullying has been identified as an issue for students with chronic health issues including obesity, disordered eating, learning disabilities, autism, and attention deficit hyperactive disorder (Hendershot, Dake, Price, & Lartey, 2006; Meyer & Gast, 2008; Robinson, 2006). In addition, 33% to 49% of

students whose sexual orientation is lesbian, gay, bisexual, transgender, or questioning report being victimized at school (Selekman, 2007). Chronic bullying can lead to depression, academic failure, and absenteeism (Raskauskas & Stoltz, 2004).

Domestic violence affects every member of the household. It is estimated that between 3 and 10 million children are exposed to some form of violence in their homes each year. This exposure puts the students at risk for developing a variety of problems including depression, anger, aggression, or anxiety (Kolar & Davey, 2007). Domestic violence also puts the child at an increased risk for sexual and physical abuse, post-traumatic stress disorder, and becoming an abuser as an adult (Homor, 2005). The number of homeless youth is estimated to be 1.3 to 2 million, of which approximately 1 million are runaways. Physical or sexual abuse is a common reason for adolescents running away from home. However, their homelessness places them at a much higher risk for physical and sexual abuse (Taylor-Seehafer, 2004).

Adverse childhood events defined as abuse, neglect, or household dysfunction lead to childhood and adolescent risky behavior, including pregnancies, suicide attempts, smoking, sexual activity, and drug use (Middlebrooks & Audage, 2008). In addition, research is now showing that the number and types of adverse events experienced as a child is linked to health and behavioral problems as adults, including alcoholism, depression, illicit drug use, multiple sexual partners, sexually transmitted diseases, and suicide attempts (Middlebrooks & Audage, 2008).

Barriers to mental health care include inadequate funding at the state and federal level, uninsured and insufficient or no coverage for mental health, managed care barriers, lack of transportation, financial constraints, shortage of trained child mental health professionals, and the social stigma related to mental health issues. In addition, physicians in primary care practices and the emergency room setting are not sufficiently prepared in their training to recognize and address mental health problems (AAP, 2004; AAP, 2006). These barriers may explain why many people attend only one or two sessions of therapy and approximately 40% to 60% of families who access mental health services end therapy prematurely (AAP, 2004).

Prevention, early identification, and intervention will ensure more successful outcomes for students. School nurses are often the health care professionals who first identify the subtle signs that have been associated with emotional or behavior issues in children. These signs can include frequent somatic complaints and unexplained physical symptoms with no medical reason (DeSocio & Hootman, 2004). Behavior problems in school, absenteeism, and academic problems can also be signals of underlying mental health issues. (DeSocio & Hootman, 2004; Goldenring & Rosen, 2004). Children with emotional, behavioral, and developmental problems on average miss at least 11 school days or more (CDC, 2005). Absenteeism rates for inner city teens can range from 15% to 20% (Goldenring & Rosen, 2004). Furthermore, the more lost school time the student has, the more likely the student is to experience academic difficulties.

RATIONALE:

School nurses promote student success and nurture positive youth development by using a systematic approach to healthy social and emotional development that strengthens students, families, schools and communities. School nurses enhance a positive school climate by becoming part of their school district's interdisciplinary team whose responsibility it is to create safe school environments. This interdisciplinary team promotes school-based curricula and initiatives that teach and role-model to children and adolescents positive self-esteem, tolerance, cultural diversity, resiliency behaviors and protective buffers, help-seeking behaviors, anti-bullying programs, anti-violence programs, and suicide prevention programs. Through early identification and treatment of problems, school nurses help students to manage chronic health conditions, thereby improving their attendance and enhancing their ability to achieve academic success. Using their advocacy skills, school nurses promote family-centered care and link parents and children with school and community resources for mental health services and monitor continued treatment and follow-up. For students with a mental health diagnosis, school nurses are able to promote their success through developing and implementing 504 plans, the health portion of the Special Education Individual Education Plan (IEP), and the Individualized Healthcare Plan (IHP). Using these same tools, the school nurse can assist in the re-entry of students into the school environment following homebound instruction or hospitalization and serve as a liaison between community mental health providers, the family, and school personnel.

Using a holistic approach, school nurses provide ongoing assessment, intervention, and follow-up of the mental and physical health of the school community. School nurses also provide education for the school staff to enable staff to recognize signs and symptoms of potential mental health issues and help build the capacity of the staff to address barriers to learning. In addition, School Nurses educate staff about the negative effects that bullying and victimization have on students and their ability to learn. They strategize with the staff about how to prevent opportunities for bullying in the school environment thereby promoting a safe learning environment for the student body.

School nurses recognize that positive mental health is essential for academic success and that services providing prevention, early identification, intervention, and treatment of mental illness are necessary to support student achievement. Services that are easy to access and provide comprehensive coordinated programs are needed to reduce the impact of mental health problems on the learning process. The stigma of a mental health diagnosis, fragmentation of care, and barriers to mental health services need to be eliminated. By joining forces with other health professionals in the school setting and the community, school nurses can act as strong advocates for child mental health programs in the political and public arena.

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Nursing Minimum Data Set for School Nursing Practice

Position Statement



SUMMARY

It is the position of the National Association of School Nurses (NASN) to support the collection of essential nursing data as listed in the Nursing Minimum Data Set (NMDS). The NMDS provides a basic structure to identify the data needed to delineate nursing care delivered to clients as well as relevant characteristics of those clients. Structure and standardization of data is essential for the efficient utilization of Electronic Health Records (EHRs) so that health information is meaningful and can be shared electronically or exchanged across settings and with different health care providers. With the current emphasis on meaningful use of health data contained in EHRs, registered professional school nurses (hereinafter referred to as school nurse) need to be aware of the importance of including school health data in EHRs to participate in the electronic exchange of useful health information with other health care providers to insure continuity and quality of care (Johnson & Bergren, 2011). To accomplish this, EHRs require standardized, meaningful data integrating data sets such as the NMDS. Ongoing evaluation will be needed to determine the usefulness of the NMDS and its ability to capture the data needed to validate the contributions of school nursing services to the health care system or if additional data elements are needed to establish a data set unique to school nursing.

HISTORY

Health information has been collected electronically for decades in hospitals and other health care settings. The Uniform Minimum Health Data Set (UMHDS), designed to identify national health data, standards and guidelines, was developed in 1969 (Ryan & Delaney, 1995). In 1983, the United States Health Informational Policy Council defined the UMHDS as “a minimum set of items of information with uniform definitions and categories, concerning a specific aspect or dimension of the health care system, which meets the essential needs of multiple data users” (Ryan, & Delaney, 1995, p. 170). The use of “standardized data sets facilitate[s] the linkage of information in one data set to other data sets. This allows the data in clinical information systems to be linked with administrative and other data sets for analysis” (Moorhead, Johnson, Maas, & Swanson, 2008, p. 12). Other health information data sets were developed in the early 1990s; however, none included nursing data.

The contribution of nursing to the health care system is invisible and unknown without nursing data incorporated into existing data sets such as the UMHDS. It is essential to have data to describe what nurses do, to whom they deliver care, and what the effectiveness and cost of that care is (Denehy, 2010). The NMDS was developed by Harriet Werley and colleagues in 1985 in response to the need for nursing data in information systems. The NMDS is defined as a minimum set of data elements with uniform definitions and categories about specific dimensions of nursing. NMDS is a standardized way to describe nursing care, clients, and services provided that will facilitate documenting and communicating nursing’s contribution to the health care system. Its purposes are to (a) establish comparable nursing data across clinical populations, settings, geographic areas, and time; (b) describe the nursing care of patients/clients and their families in a variety of settings; (c) demonstrate or project trends regarding nursing care provided and the allocation of resources to patients/clients based on their health problems or nursing diagnoses; (d) stimulate nursing research through links to data existing in nursing and other health care information systems; and (e) provide data about nursing care to influence clinical, administrative, and health policy decision-making. The NMDS is designed to meet the information needs of multiple data users in the health care system (Werley & Lang, 1988).

DESCRIPTION OF ISSUE

Documentation of nursing care delivered in the school setting is listed as a measurement criteria for each of the six standards of practice listed in *The Scope and Standards of Practice – School Nursing* (NASN, ANA, 2005, pp. 9-23). While paper and pencil documentation has long been a part of school nursing practice, the advent and increasing use of EHRs in all health care settings, including schools, provide the “structure and opportunity to standardize and collect consistent data across multiple health care settings, with the intent of improving the quality of health care” (Yearous, 2011, p. 20). To achieve this, specification of the data to be collected on each student is prerequisite to developing large databases that will make it possible to identify and analyze relationships that will lead to identifying best practices and more efficient and cost effective care, as well as providing data for research.

The NMDS provides the formal structure and identification of data elements, including nursing care delivered in all settings, for EHRs. It is similar to other health care data sets except that it includes four nursing care elements and a unique provider number for each health care provider. The 16 elements of the NMDS are as follows:

NURSING CARE ELEMENTS

Nursing diagnosis
Nursing intervention
Nursing outcome
Nursing intensity

CLIENT ELEMENTS

Unique individual identifier number
Date of birth
Gender
Race and ethnicity
Residence

SERVICE PROVIDER ELEMENTS

Unique facility identifier
Unique health record number
Unique health provider identifier
Encounter date
Discharge date
Disposition of client
Expected payer of bill

To accurately and consistently document, store, aggregate, and retrieve nursing care information, the use of standardized terminology or languages to describe client data and care delivered is essential (Brokel & Heath, 2009). Several nursing classifications of standardized nursing languages are recognized by the American Nurses Association (ANA, 2006). The languages often used by school nurses that have met the standards for recognition by the ANA and are supported by NASN (NASN, 2006) are: NANDA-International (NANDA-I, 2009), Nursing Interventions Classification (NIC) (Bulechek, Butcher, & Dochterman, 2008), Nursing Outcomes Classification (NOC) (Moorhead et al., 2008), and Omaha System-Community Health Classification System (Martin, 2005). These languages provide the standardized terminology needed to describe the Nursing Care Elements of the NMDS. A preliminary nursing data set for school nursing has been developed (Fahrenkrug, 2003) but has yet to be refined and used in practice.

RATIONALE

The goal of school nursing is to promote the health and academic success of students. “School nurses need concrete evidence/data to show what they contribute to the health and educational achievement of students” (Denehy, 2010, p. 34). School nurses should understand, recognize, and support the systematic collection of essential school nursing data. Although it has not been tested in the school setting and may not capture all the data elements unique to school nursing, the NMDS provides the initial structure to identify the data needed to delineate nursing care delivered to clients as well relevant characteristics of those clients. Such structure is essential in EHRs. The NMDS has the potential to assist school nurses in the documentation and validation of their practice in a meaningful way. “In addition, it will provide a structure for data specific to school nursing that can demonstrate the complexity of the school nurse role, the resources needed to effectively implement the plan of care, and the effect of other variables on the outcomes of nursing care” (Denehy, 2010, p. 34).

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Overweight and Obesity in Youth in Schools-

The Role of the School Nurse

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that school nurses have the knowledge and expertise to promote the prevention of overweight and obesity and address the needs of overweight and obese youth in schools. The school nurse collaborates with students, families, school personnel, and health care providers to promote healthy weight and identify overweight and obese youth who may be at risk for health problems. The school nurse can refer and follow up with students who may need to see a health care provider. The school nurse also educates and advocates for changes in the school and district that promote a healthy lifestyle for all students.

HISTORY

Overweight and obesity are an increasing problem in the United States that often begins in childhood. Obesity in children can lead to serious health concerns, once only seen in adults. The rates for overweight and obesity in youth have tripled in the past 30 years, and currently almost 32% of youth between 2 and 19 are overweight or obese, at or above the 85th percentile (Centers for Disease Control [CDC], 2010).

DESCRIPTION OF ISSUE

The etiology of overweight and obesity is not completely understood but thought to be complex and have multifactorial contributing factors (Crawford et al., 2010; Johnson, Williams & Spruill, 2006; CDC, 2009). Contributing factors may include:

- Change in diet and physical activity
- Heredity/Genetics
- Family/Social factors
- Behavioral/Cultural
- Environmental/Socioeconomic status
- Media marketing

Children and adolescents who are overweight and obese are at higher risk for health concerns such as: (CDC, 2008; Copstead-Kirkhorn & Banasik, 2009):

- Coronary heart disease
- High cholesterol
- High blood pressure
- Bone and joint problems
- Sleep apnea
- Asthma
- Social and psychological problems
- Stigmatization and poor self-esteem
- Type 2 diabetes

Good quality nutrition and physical activity are essential for growth, development, and well-being. Behaviors that encourage healthy nutrition, portion control, and physical activity should be promoted early in childhood and continue throughout the life span. To maintain a healthy weight, children and families should incorporate nutritionally balanced eating patterns and daily physical activity of a moderate to vigorous level for at least 60 minutes each day. The *Dietary Guidelines for Americans* states that eating patterns established in youth often last into adulthood making early development of healthy nutrition and physical activity behaviors a priority (U.S. Department of Agriculture [USDA] & USDHHS, 2010).

The *Physical Activity Guidelines for Americans* states that regular physical activity in youth promotes health and fitness and makes it less likely they will develop risk factors for chronic illnesses and more likely that youth will continue as healthy adults (USDHHS, 2008).

RATIONALE

Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2011) identifies specific goals to achieve and promote maintenance of healthy body weights. Since most children spend a large portion of their day at school, the school is a key setting to implement strategies to address this issue. The school can provide a healthy environment that supports balanced nutrition and activity.

The school nurse has the capacity to reach a large number of youth, can provide essential leadership in helping students maintain a healthy weight to prevent overweight and obesity and decrease the burden of illness, and increase the quality of life and life expectancy. School nurses are able to address the potential serious health problems resulting from overweight and obesity.

The reality of preventing and treating overweight and obesity requires multiple strategies. A school nurse can impact a child and his/her family to make healthy lifestyle changes through:

- Identifying students who may need further evaluation by conducting screenings (height, weight and body mass index [BMI]) and assessing students for possible risk factors associated with overweight and obesity (hypertension, acanthosis nigricans, risk for type 2 diabetes, and family history);
- Making necessary referrals to health care providers for further assessment and treatment;
- Developing individualized health plans that address elevated BMIs which place students at risk for chronic health concerns;
- Identifying community resources for referral for overweight and obese students;
- Providing education and information to parents and families about nutrition, physical activity and community resources;
- Encouraging follow up for counseling and psychological support for students;
- Promoting healthy messages that encourage the consumption of healthy foods and encourage physical activity in and after school;
- Encouraging role modeling of healthy lifestyle choices by parents and teachers;
- Promoting nutrition and activity assessment by the school to help the child and adolescent identify healthy behaviors and set goals; and
- Educating the school community about evidence based healthy lifestyle changes, daily physical activity requirements, and preventable health risks associated with overweight/obesity.

School nurses initiate and lead the school community to influence policy and protocols related to wellness and can be the primary force in:

- Development of youth-related wellness policies,

- Prevention and treatment of obesity among school staff members, as school staff often serve as role models for students,
- Promoting walk to school and bike to school programs, and
- Advocating for:
 - Community and school facilities to be available for physical activity for all people including after school and weekend times,
 - Research on the behavioral and biological causes of overweight and obesity,
 - Proper education to community youth organizations about the importance of making healthy food choices and obtaining the daily recommended amount of physical activity,
 - The importance of proper nutrition in enhancing learning and increasing brain function,
 - Nutritional school lunches,
 - Easy access to drinking water, and
 - Daily physical education at all schools.

School nurses recognize the impact of healthy eating and physical activity on academic success, promote healthy lifestyles for all students, and assist students who are overweight and obese obtain a healthy lifestyle. School nurses are in the prime position to influence the behavior of children and adolescents in developing good decision-making skills related to nutrition and physical activity to develop and achieve healthy lifestyles.

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Pediculosis Management in the School Setting

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that the management of pediculosis (infestation by head lice) should not disrupt the educational process. No disease is associated with head lice, and in-school transmission is considered to be rare. When transmission occurs, it is generally found among younger-age children with increased head-to-head contact (Frankowski & Bocchini, 2010).

Children found with live head lice should remain in class, but be discouraged from close direct head contact with others. The school nurse should contact the parents to discuss treating the child at the conclusion of the school day (Frankowski & Bocchini, 2010). Students with nits only should not be excluded from school (American School Health Association, 2005, Frankowski & Bocchini, 2010, Pollack, Kiszewski & Spielman, 2000), although further monitoring for signs of re-infestation is appropriate. It may be appropriate to screen other children who have had close head-to-head contact with a student with an active infestation, such as household family members, but classroom-wide or school-wide screening is not merited (Andresen & McCarthy, 2009). In cases that involve head lice, as in all school health issues, it is vital that the school nurse prevent stigmatizing and maintain the student's privacy as well as the family's right to confidentiality (Gordon, 2007).

The school nurse, as a student advocate and nursing expert, should be included in school district-community planning, implementation, and evaluation of vector control programs for the school setting. School nurses are also in a pivotal position to dispel myths and stigmas regarding pediculosis by providing education on the life cycle of the louse, methods of transmission, treatment options and care of the environment to the student's family, school and community at large.

HISTORY

Head lice (*pediculosis capitis*) are small parasitic insects that live on the scalp and neck hairs of their human hosts. The presence of lice is most often detected through the presence of adult lice or nits (eggs) attached to the hair shaft of the host, most often at the nape of the neck and behind the ears. Complications of infestations are rare and involve secondary bacterial skin infection (Lebwohl, Clark & Levitt, 2007). Pruritis (itching) is the most common symptom of a lice infestation, along with the following additional symptoms:

- a tickling feeling or a sensation of something moving in the hair;
- irritability and sleeplessness; and
- sores on the head caused by scratching. Sores caused by scratching can sometimes become infected with bacteria normally found on a person's skin (CDC, 2010).

DESCRIPTION OF ISSUE

Some people consider pediculosis to be a public health issue that is brought into the school setting. Families and school staff expend innumerable hours and resources attempting to eradicate lice infestations, both live lice and their nits. The Centers for Disease Control and Prevention (CDC) (2010) reports an estimated 6 million to 12 million infestations (some experts believe that the true prevalence is considerably lower) (Pollock, 2010) occur each year in the United States among children 3 to 11 years of age. It is thought that head lice infestations are often misdiagnosed when medical and lay individuals identify the presence of lice based on the presence of eggs

(Pollack, Kiszewski & Spielman, 2000). In addition, millions of dollars are spent annually on pediculicides, lice combs, physician visits, and parental time away from work. In an effort to find an easy, effective, and safe treatment, a variety of alternative therapies (e.g., occlusive agents such as oil-based and grease-based products, electric combs, herbal shampoos and enzyme solutions,) have been attempted by parents. There is little scientific evidence regarding the effectiveness of these alternative treatments, and all have an associated cost (Frankowski & Bocchini, 2010). Treatment recommendations for pediculosis should be based on evidence based literature from public health, medical and nursing content experts rather than anecdotal reports or commercial advertisements.

Parents, school staff, and the community often become unduly anxious when a case of head lice occurs within a classroom, and this anxiety is multiplied if more than one case is identified. A negative social stigma frequently accompanies the identification of pediculosis as well as the frustration involved with the cost, time and effort needed for treatment and environmental control (Gordon, 2007). It is important, as a part of a comprehensive educational program, that the school nurse emphasizes that head lice are not associated with poor hygiene (Lebwohl, Clark & Levitt, 2007).

In 2007, international guidelines established for effective control of head lice infestations reinforced that policies that required a student to be free of nits to attend school, known as “no nit” policies, were based on misinformation rather than objective science and were therefore unjust and should be discontinued (Mumcuoglu et. al., 2007). The CDC (2010) cites the following reasons to discontinue “no nit” policies in school:

- Many nits are more than ¼ inch from the scalp. Such nits are usually not viable and unlikely to hatch to become crawling lice, or may in fact be empty shells, also known as casings.
- Nits are cemented to hair shafts and unlikely to be transferred successfully to other people.
- The burden of unnecessary absenteeism to the students, families and communities far outweighs the risks associated with head lice.
- Misdiagnosis of nits is very common during nit checks conducted by nonmedical personnel.

RATIONALE

The school nurse is the key health professional to provide education and anticipatory guidance to the school community regarding best practice guidance in the management of pediculosis. The school nurse’s goals are to facilitate an accurate assessment of the problem, contain infestation, provide appropriate health information for treatment and prevention, prevent overexposure to potentially hazardous chemicals, and minimize school absence.

There is discussion in the scientific community on the best way to control head lice infestation in school children. No pediculicide is 100% ovicidal, and resistance has been reported with lindane, pyrethrins, and permethrin (Frankowski & Bocchini, 2010). New categories of pediculicides have recently been developed, including benzyl alcohol (CDC, 2010).

Head lice screening programs have not had a significant effect on the incidence of head lice in the school setting over time and have not proven to be cost effective (Frankowski & Bocchini, 2010). Research data does not support immediate exclusion upon the identification of the presence of live lice or nits as an effective means of controlling pediculosis transmission. By the time a child with an active head lice infestation has been identified, he or she may have had the infestation for one month or more and, therefore, poses little additional risk of transmission to others (Frankowski & Bocchini, 2010). The school nurse is in a position to take the lead in eliminating school

exclusion policies and, instead, incorporate evidence-based practices that reduce the stigma associated with head lice, and work to increase classroom time with an emphasis on keeping students in school (Gordon, 2007).

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Pregnant and Parenting Students-

The Role of the School Nurse

Position Statement



SUMMARY

The National Association of School Nurses (NASN) believes that the school nurse is in a prime position to support the health and wellbeing of pregnant and parenting students and contribute to their lifelong success by linking them to resources and advocating for policies and practices that promote high school graduation. It is the position of NASN that school nurses have a vital role in the development and implementation of evidenced-based policies, nursing care procedures, educational programs and materials for students and their parents relating to pregnancy prevention, teen parenting and school completion. School nurses track pregnancy trends, review the school's human growth and development curriculum, assist in the selection of high-quality educational materials and programs based on the age, culture, and level of risk of the target population, and evaluate the short-term and long-term outcomes of the school's programs.

The role of the school nurse with pregnant and parenting students is complex and includes assistance in pregnancy identification, providing parenting education, support in preventing additional pregnancies, and participation / leadership of multidisciplinary teams that plan and support accommodations for the student (Will, 2008).

HISTORY

"The teenage birth rate declined 8 percent in the United States from 2007 through 2009, reaching a historic low at 39.1 births per 1,000 teens aged 15-19 years" (Ventura & Hamilton 2011), but continues to be among the highest in western industrialized nations (Martin, J.A., et al. 2010). About three quarters of a million teenagers become pregnant each year and over half of these will give birth and become parents (Kost, Henshaw & Carlin, 2010). Thirty to fifty percent of all adolescent mothers have a second pregnancy and about 25 % have a repeat birth within two years of the first (National Campaign to Prevent Teen Pregnancy [NCPTP], 2010a).

The passage of Title IX of the Education Amendment Act in 1972 prohibited discrimination against pregnant and parenting students in public schools (SmithBattle, 2006). These students are entitled to a free and appropriate education in the least restrictive environment (some students may attend alternative education programs). Parenting students must have accommodations to their educational program to meet their specific or individual needs. (SmithBattle, 2006).

DESCRIPTION OF ISSUE

Centers for Disease Control and Prevention (CDC)(2011) data shows that while teen birth rates have declined, data varies by state with more births to teens in southern states. Teen birth rates are especially high among black and Hispanic teens compared to white teens (CDC, 2011). With only 40% of teen mothers finishing high school (America's Promise Alliance /NCPTP, 2010), the economic impact can be devastating. It is estimated that over the

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course of her lifetime, a single high school dropout costs the nation approximately \$260,000 in lost earnings, taxes and productivity. (Alliance for Excellent Education, 2008). Despite advanced medical care in the US, infants born to teens are at greater risk for preterm birth, low birth weight and infant mortality costing the nation approximately \$3 billion in public expenditures (CDC, 2011).

The well-being of pregnant and parenting adolescents influences the physical, cognitive, behavioral and emotional status of their children. Teen parents are at risk for dropping out of school and more likely to have additional teen pregnancies affecting their current and future socio-economic level. Children of teen mothers start school at a disadvantage with lower “levels of school readiness—including lower math and reading scores, language and communication skills, social skills and physical and emotional well-being” compared to children born to women in their twenties (America’s Promise Alliance /NCPTP, 2010).

The adolescent parent’s developmental, social, and economic concerns need to be considered when programming education and connecting them with community resources. Comprehensive evidence-based programs, including school-based infant and childcare, and effective parenting practices, can promote high school completion rates and enhance the health of the adolescent parents and offspring. Programs should be tailored to specific communities and include programs that teach youth knowledge and skills (Ball & Moore, 2008).

RATIONALE

Supporting students in “school achievement, attendance, and involvement can help reduce the risk of teen pregnancy “(NCPTP, 2010b). School nurses play a vital role in helping students understand their sexuality and making responsible choices that will affect their future. As trusted health professionals, school nurses provide nursing care during a student’s pregnancy, offer guidance for decision-making and accessing community resources including state or federal welfare and legal assistance. School nurses collaborate with the student, family, school staff, and medical providers to plan for the care and academic success of the student during pregnancy. The school nurse writes Individual Health Plans (IHP) to assess the needs of each pregnant student and documents compliance with medical treatments and general health status (Marcontel-Shattuck, 2006).

Adolescents play an important role in identifying and establishing solutions to meet their own needs. School nurses encourage adolescents’ active participation in the development of pregnancy prevention and teen parenting programs. School nurses provide support and interventions to the childbearing adolescent as her pregnancy progresses and recommend modifications necessary for the safety and well-being of the student in the school setting. The school nurse can assist teen fathers by providing educational programs addressing responsibilities of fatherhood (Will, 2008). Studies reflect that social support of the pregnant teen and their significant others (parent, boyfriend, etc.) has a positive impact on the pregnant teen’s ability to cope with stress during pregnancy and parenthood (Devereux, Weigel, Ballard-Reisch, Leigh, & Cahoon, 2009). The school nurse working with adolescent parents can create a parent friendly school culture for teen parents, and advocate for comprehensive school site childcare facilities to foster high school completion rates (Will, 2008).

National and local programs aimed at pregnancy prevention and fostering parenting skills for those adolescents with children have steadily increased over the last several decades. In attempting to disrupt the intergenerational cycle of adolescent parenthood, school nurses can promote positive parenting practices, support responsible parenthood through evidenced-based programming and connect parenting students with school and community resources. School nurses can be instrumental in helping adolescent parents plan for their long-term future. By developing a supportive relationship with a student parent, the school nurse can affect the future of the student by encouraging the postpartum adolescent to return to school and to prevent a subsequent teen pregnancy.

School nurses collaborate with policy makers, local school superintendents and state officials, to support the connection between education and teen pregnancy. Adoption of action plans to address teen pregnancy and parenting is a key component of any school completion strategy and preparing young men and women to succeed in the 21st century.

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Role of the School Nurse



Position Statement

SUMMARY

It is the position of the National Association of School Nurses that the registered professional school nurse is the leader in the school community to oversee school health policies and programs. The school nurse serves in a pivotal role to provide expertise and oversight for the provision of school health services and promotion of health education. Using clinical knowledge and judgment, the school nurse provides health care to students and staff, performs health screenings and coordinates referrals to the medical home or private healthcare provider. The school nurse serves as a liaison between school personnel, family, community and healthcare providers to advocate for health care and a healthy school environment (National Association of School Nurses / American Nurses Association [NASN / ANA], 2005).

HISTORY

The practice of school nursing began in the United States on October 1, 1902, when a school nurse was hired to reduce absenteeism by intervening with students and families regarding health care needs related to communicable diseases. After one month of successful nursing interventions in the New York City schools, Lina Rogers, the first school nurse, was able to provide leadership to implement evidence-based nursing care across the city. The school nurse's role has expanded greatly from its original focus, the essence and goals of the practice remains the same (Vessey & McGowan, 2006).

DESCRIPTION OF THE ISSUE

A student's health status is directly related to his or her ability to learn. Children with unmet health needs have a difficult time engaging in the educational process. The school nurse supports student success by providing health care through assessment, intervention, and follow-up for all children within the school setting. The school nurse addresses the physical, mental, emotional, and social health needs of students and supports their achievement in the learning process. The school nurse not only provides for the safety and care of students and staff but also addresses the need for integrating health solutions into the education setting.

The number of students with chronic illness and/or special health care needs has increased dramatically over the past decade. Students are coming to school with increasingly complex medical problems, technically intricate medical equipment, and complicated treatments (Robert Wood Johnson Foundation, 2010). The number of children that have a chronic condition has increased dramatically over the past four decades (Perrin, Bloom, Gortmaker, 2007). Chronic conditions such as asthma, anaphylaxis, Type 1 Diabetes, epilepsy, obesity and mental health concerns may impact the student's ability to be in school and ready to learn.

The school nurse is a registered professional nurse who has a commitment to lifelong learning. Educational preparation for the school nurse should be at the baccalaureate level, and the school nurse should continue to pursue professional development and continuing nursing education. School nurses typically practice independently and are called upon to assess student health, develop and execute plans for care management, act

as first responders, and engage in public health functions such as disease surveillance, immunization compliance, and health promotion. The school nurse is a vital member of the school team that leads change to advance health and collaborates with school staff members, parents and community members to keep students safe at school and healthy to learn.

RATIONALE

School nursing has multiple components and the role of the school nurse is a broad one, dependent on many factors, including the school setting (rural, urban, suburban), health needs of the student population and the availability of specialized instructional student support services and programs.

The National Association of School Nurses defines school nursing as a specialized practice of professional nursing that advances the well-being, academic success and lifelong achievement and health of students. To that end, school nurses facilitate normal development and positive student response to interventions; promote health and safety including a healthy environment; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self advocacy, and learning (National Association of School Nurses [NASN], 2010).

- **School nurses facilitate normal development and positive student response to interventions.**
The school nurse serves as the health care expert in the school to meet student health needs with an understanding of normal growth and development in children and youth as well as students with special needs. The school nurse develops plans for student care based on the nursing process, which includes assessment, interventions, and identification of outcomes and evaluation of care (Wolfe, 2012).
- **School nurses provide leadership in promoting health and safety, including a healthy environment.**
The school nurse provides health-related education to students and staff in individual and group settings and provides consultation to other school professionals, including food service personnel, physical education teachers, coaches, and counselors. Responsibilities in the provision of a safe and healthy school environment include the school nurse's monitoring of immunizations, managing communicable diseases, assessing the school environment for safety to prevent injury and spearheading infection control measures. The school nurse is also a leader in the development of school safety plans to address bullying, school violence, and the full range of emergencies that may occur at school (Wolfe, 2012).
- **School nurses provide quality health care and intervene with actual and potential health problems.**
Health care for chronic and acute illness, as well as injuries in the school setting, is a major focus of the role of the school nurse. The school nurse is responsible for medication administration, health care procedures, and the development of health care plans. Students often have multiple needs that should be examined in order for the student to be able to be successful in the classroom, and school nurses often engage in health screenings that include vision, hearing, body mass index, mental health index or other screening procedures (often based on local and state regulations) to address those issues (Wolfe, 2012).
- **School nurses use clinical judgment in providing case management services.**
The school nurse receives medical orders to guide the health care needed to assist each student to be safe and successful at school. As in other clinical settings, the nurse develops Individualized Healthcare Plans (IHPs) in nursing language to direct nursing care for students as well as Emergency Care Plans (ECPs) written in lay language to guide the response of unlicensed personnel in a health-related emergency. Both plans are tailored to the individual needs of a specific student to improve expected care outcomes.

The nurse makes decisions related to the appropriate delegation of healthcare tasks as directed by state laws and professional practice guidance (American Nurses Association [ANA]/National Council of State Boards of Nursing [NCSBN], 2006). As medical and information technology advance and change, it is imperative for the school nurse to pursue professional development so the school nurse is able to provide the best possible care for the student population (Wolfe, 2012).

- **School nurses actively collaborate with others to build student and family capacity for adaptation, self-management, self advocacy and learning.**
Coordinating the linkage between the medical home, family and school is an important aspect of the role of the school nurse. The school nurse has health expertise that is essential to school educational teams, such as the Committee on Special Education, the Individualized Educational Plan (IEP) team and the Section 504 Team so that health-related barriers to learning can be reduced for each student. The school nurse can provide families with referral information along with available community resources to improve access to health care. The school nurse can also assist families in obtaining health insurance as needed and can represent the school on community coalitions to advocate for school-based health care (Wolfe, 2012).

The school nurse may take on additional roles as needed to meet the needs of the school community.

Healthy children are successful learners. The school nurse has a multi-faceted role within the school setting, one that supports the physical, mental, emotional, and social health of students and their success in the learning process. It is the breadth of nursing activities contained within the role of the school nurse and the unique non-medical setting that differentiates school nursing from other nursing specialties.

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The Role of the School Nurse and

School Based Health Centers

Position Statement



SUMMARY

The National Association of School Nurses holds the position that a combination of school nursing services and school-based health centers (SBHCs) can facilitate positive health outcomes for students. SBHC services complement the work of the school nurses, who are responsible for the entire population of students, by providing a referral site for students without another medical home. SBHCs may provide primary nursing, medical, dental, mental health and other services to those students enrolled in the SBHC program. When available, SBHCs should be integrated with school nursing services to provide a continuum of health services to keep students healthy, in school, and ready to learn. Funding for SBHCs and school nurses typically comes from different sources, so the relationship should be complementary and not competitive.

HISTORY

SBHCs started during the 1970s in elementary schools to provide services to those who could not afford or access primary health care. There are now more than 1,900 SBHCs in the United States and, with parental enrollment, are available to many students. Almost all (81%) SBHCs are able to bill Medicaid for services (NASBHC 2010).

DESCRIPTION OF THE ISSUE

School health services support student needs and there is a strong correlation between the presence of a SBHC and academic achievement (Vinicullo & Bradley, 2009). SBHCs improve access to care by removing barriers, including:

- lack of insurance or money,
- lack of a provider who will accept the student's insurance,
- lack of transportation to appointments, and
- inability of a parent to leave work for a student's medical appointment.

Services that are offered by SBHCs are culturally sensitive and age-appropriate and may include:

- treatment of acute illness,
- physical examinations for school entrance or sports participation,
- dental screening and treatment,
- pregnancy testing
- diagnosis and treatment of sexually transmitted infections,

- reproductive health counseling
- mental health services
- crisis intervention
- diagnosis and interventions for learning or behavioral problems,
- nutrition counseling
- substance abuse counseling
- tobacco cessation programs,
- social services,
- laboratory testing,
- immunizations, and
- medication prescription and dispensing. (Lear, et al)

SBHCs provide students with preventative and primary health care services in school rather than in a traditional manner that includes missed days of school or parental absence from the workplace (Luehr & Selekman, 2006). Centers virtually bring the “doctor's office” to the school, increasing classroom attendance time so that students are provided the health related support they need to succeed in the classroom (NASBHC, 2010).

RATIONALE

School nurses are in a unique position to provide the critical link between the education system, students, families, community, and medical care. Within that framework, the school nurse should function as part of the healthcare team by assisting in the development of rationale for a SBHC, facilitating access to the full array of services to the SBHC for students, and referring and coordinating care for students who are enrolled for care in the SBHC.

The SBHC should include the school nurse in all phases of planning, implementing, and evaluating a SBHC. In addition, the SBHC should include the school nurse as a member of a team that provides health services for shared clients utilizing a holistic health approach.

As a partnership, the school nurse and the SBHC staff should develop a shared case management structure to track outcomes of care, coordinate nursing and treatment care plans for students who require follow-up care, and work together to collect data to study outcomes and cost effectiveness of care. The collaboration between the school nurse and the SBHC staff can also be aimed at the development of policies and systems that ensure the quality and confidentiality of care received by students and implement wellness and disease prevention programs to improve health outcomes for all members of the school community

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School Health Education about Human Sexuality



Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that age-appropriate health education about human sexuality should be included as part of a comprehensive school health education program and be accessible to all students in schools. NASN recognizes the role of parents and families as the primary source of education about sexual health. The registered professional school nurse (hereinafter referred to as school nurse) plays a vital role in the development and implementation of instructional programs that utilize evidence-based strategies to prevent unintended pregnancies and sexually transmitted infections including HIV.

HISTORY

The teen birth rate in United States is declining but remains higher than in other developed countries (CDC, 2011a). Even in states with the lowest teen birth rates, those rates are nearly three to five times higher than in developed countries with the lowest birth rates; in states with the highest rates, the teen birth rate is approximately ten to fifteen times higher than in other developed countries with the lowest birth rates (CDC, 2011a).

The majority of parents and students in the United States support education about human sexuality in schools. In 2004, Kaiser Family Foundation and Harvard's Kennedy School of Government reported that 93% of Americans polled said sex education should be taught in schools. 75% believe that the topic of sexual orientation should be included in sexuality education programs and "discussed in a way that provides a fair and balanced presentation of the facts and different views in society" (National Sexuality Education Standards, 2012, p.8). Another study surveyed 1605 parents and found that the majority of parents indicated that young people should receive most of their information regarding sex from parents (97.9%) and teachers (58.5%). However, most parents reported friends and classmates (77.7%) and media (60.3%) to be the most common sources of information (Lagus, Bernat, Bearinger, Resnick, & Eisenberg, 2011).

Despite the extent of parental and student support, only 69% of high schools offer a course in health education. Not all of those courses offered use effective curricula and/or instructional methods, and some courses do not include key information needed by adolescents to make safe choices about their sexual behavior (CDC, 2010).

DESCRIPTION OF THE ISSUE

Data from the 2009 Youth Risk Behavior Surveillance Survey (YRBSS) indicated that, among high school students, 46.0% have had sexual intercourse at least once and 34.2% had sexual intercourse in the three months prior to completing the survey; 13.8% had intercourse with four or more people; and 5.9% of students surveyed had sexual intercourse for the first time before age 13 years. Of the sexually active students, 22.9% reported using either birth control pills or Depo-Provera to prevent pregnancy. In addition, 61.1% reported that either they or their partner had used a condom during last sexual intercourse (CDC, 2010).

Sexual behaviors and academic achievement are related. Students in grades 9-12 in the United States who initiate sexual intercourse before the age of 13 and those teens with four or more sexual partners are more likely to have grades of Ds and Fs and are less likely to graduate from high school compared to their peers who are not sexually active (CDC, 2009).

Sexual health education must be accessible as well as developmentally and culturally appropriate for all students. Health disparities and higher risk behaviors are evident in specific populations. These disparities highlight the importance of providing sexual health education that is accessible for all students.

According to the 2009 National School Climate Survey (Kosciw, 2012), nearly 9 out of 10 lesbian, gay, bisexual or transgender (LGBT) students reported being harassed in the previous year. Two-thirds of LGBT students reported feeling unsafe, and nearly one-third skipped at least one day of school because of concerns about their personal safety. LGBT students who reported frequent harassment also suffered from lower grade point averages (Kosciw, 2012).

Data from the 2009 Youth Risk Behavior Survey (YRBS) and publications of the American Academy of Pediatrics indicate increased risks for LGBT students include sexually transmitted infections, unintended pregnancies, violence, being victims of bullying, alcohol and other drug use, tobacco use, depression, suicide, and problems with weight management (CDC, 2011a; Frankowski 2004).

In addition to the disparities of risk for sexual minority youth, there are racial/ethnic differences. Black high school students are more likely to have had intercourse than White and Hispanic students; more Black high school students and Latino/Hispanic students initiated sex before the age of 13 compared to White students (Kaiser Family Foundation, 2011).

RATIONALE

An extensive review of school health initiatives found that programs that included health education had a positive effect on overall academic outcomes, including reading and math scores (Dilley, 2009). Research overwhelmingly supports a comprehensive approach to sexual health education (CDC, 2011b; Kirby, 2008; Kirby, Coyle, Forrest, Roller, & Robin, 2011). A key strategy outlined by the National HIV and AIDS Strategy for the United States notes the importance of providing baseline information that is grounded in the benefits of abstinence and delaying sexual activity, while ensuring that youth who make the decision to be sexually active have the information they need to take steps to protect themselves (The White House Office of National AIDS Policy, 2010). Researchers recently examined the National Survey of Family Growth to determine the impact of sexuality education on sexual risk-taking for young people ages 15-19 and found that teens who received comprehensive sexuality education were 50% less likely to report a pregnancy than those who received abstinence-only education (Kohler, Manhart, & Lafferty, 2008).

According to the National Sexuality Education Standards (2012), the most effective strategy is a strategic and coordinated approach to health that includes family and community involvement, school health services, a healthy school environment and health education, which includes sexuality education. The national group of experts recommends a sexual health education program that is planned, sequential, and part of a comprehensive school health education program (National Sexuality Education Standards, 2012).

It is recommended that an effective sexuality education program include the following characteristics:

- Focuses on specific behavioral outcomes;
- Addresses individual values and group norms that support health-enhancing behaviors;
- Focuses on increasing personal perceptions of risk and harmfulness of engaging in specific health risk behaviors, as well as reinforcing protective factors;
- Addresses social pressures and influences;
- Builds personal and social competence;
- Provides functional knowledge that is basic, accurate and directly contributes to health-promoting decisions and behaviors;
- Uses strategies designed to personalize information and engage students;

- Provides age- and developmentally-appropriate information, learning strategies, teaching methods and materials;
- Incorporates learning strategies, teaching methods and materials that are culturally inclusive (an effective curriculum has materials that are free of culturally biased information and includes information, activities, and examples that are inclusive of diverse cultures and lifestyles;
- Provides adequate time for instruction and learning;
- Provides opportunities to reinforce skills and positive health behaviors;
- Provides opportunities to make connections with other influential persons; and
- Includes teacher information and plan for professional development and training to enhance effectiveness of instruction and student learning. Instruction by qualified sexuality education teachers is essential for student achievement.

School nurses can enhance the effectiveness of sexual health education by ensuring that “medically accurate, developmentally appropriate and evidence-based sexual health education provides students with the skills and resources that help them make informed and responsible decisions” (National Sexuality Education Standards, 2012). By collaborating with parents, health educators, curriculum specialists and other stakeholders, school nurses provide support for developing and implementing school health education about human sexuality that is effective in reducing students’ sexually-related risk behaviors and concurrently, improving students’ academic success.

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(Formerly titled "Reproductive Health Education")

Sexual Orientation and Gender Identity/Expression (Sexual Minority Students): School Nurse Practice

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that all students, regardless of their sexual orientation or the sexual orientation of their parents and family members, are entitled to a safe school environment and equal opportunities for a high level of academic achievement and school participation/involvement.

**Sexual minority persons are those who identify themselves as gay, lesbian, or bisexual(LGB) or are unsure of their sexual orientation, or those who have had sexual contact with persons of the same sex or both sexes (Kann et al., 2011). Sexual minority is thought to be a more inclusive and neutral term. For the purposes of this statement, the term sexual minority will be used in lieu of LGBTQ (lesbian, gay, bisexual, transgender, or questioning).*

HISTORY

Homosexuality, bisexuality, and questioning one's own sexual orientation are no longer considered health conditions/disorders that need or respond to treatment or remediation. One's sexual orientation is not a choice. Homosexuality as a diagnosis was removed from the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association in 1973. Multiple health and mental health professional organizations have taken official positions supporting that homosexuality is not a mental disorder. These include the American Academy of Pediatrics, American Counseling Association, American Psychiatric Association, American Psychological Association, American School Counselor Association, and National Association of Social Workers (American Psychological Association [APA], 2008).

Approximately 9 million Americans identify as lesbian, gay, bisexual or transgender (Gates, 2011). It is further estimated that between 6 and 9 million children in the United States have one or two parents who are homosexual (Stein, Perrin and Potter, 2004). The 2000 census indicated that the households of 33% of the female same-sex couples and 22% of male same-sex couples had at least one child under 18 living at home (Paige, 2005).

DESCRIPTION OF ISSUE

Sexual minority youth experience physical, mental, and social health risks that are higher than their heterosexual peers. Those increased risks include loneliness, lack of acceptance, violence, bullying, sexually transmitted infections (including HIV), unintended pregnancies, alcohol and other drug/substance use, tobacco use, depression, suicide, and issues with weight management (Kann et al., 2011; Kosciw, Greytak, Diaz & Bartkiewicz, 2010; Matthey, 2012). Suicide risk among sexual minority youth is significantly higher than for heterosexual youth (CDC, 2011; Hatzenbuehler, 2011). Studies also indicate that characteristics of social environments, including schools, can either increase or reduce sexual orientation-related suicides (Hatzenbuehler, 2011).

Over 84% of sexual minority youth are verbally harassed; 40% are physically harassed; and 18.8% are physically assaulted in school. They are afraid to tell their parents and often fear for their safety in school (61%); they may choose to be truant from school (30%) for safety reasons and not because they don't want to learn (Kosciw et al., 2010).

Youth at school with two parents of the same sex may experience disapproval from other students, parents, teachers or school staff; and that disapproval may serve to stigmatize or isolate them. Sexual minority parents also experience bias regarding policies that may prevent them from serving as chaperones and helpers for classroom and school activities.

When compared to children whose parents are heterosexual, there is no evidence that children of sexual minority parents are cognitively, emotionally or socially disadvantaged (Paige, 2005; Cooper & Cates, 2006). Children raised by sexual minority parents have no difficulty “establishing their feminine and masculine selves” and do not have a significantly higher rate of self-identifying as non-heterosexual than do children of heterosexual parents (Goldberg, 2010, p. 131).

RATIONALE

Registered professional school nurses (hereinafter referred to as school nurse) are uniquely positioned to do the following:

- Recognize health risks that are disproportionately high for sexual minority students;
- Provide health services that are safe, private, and confidential;
- Make referrals for evidence-based care; and
- Identify and advocate for policies in the school environment to assure physical, psychological and social safety of sexual minority students and students with gay and lesbian parents.

Establishment of Gay-Straight Alliances (GSA) and clubs at school with the support of faculty and administration improves school climate for **all** students, regardless of their sexual orientation or gender identity/expression. GSA can help to assure these youth that they are not alone; it helps them meet others like themselves; it helps them resolve conflicts between who they are and what they are being told they should be; and it allows better communication and understanding by the general school community (Kosciw et al., 2010).

School nurses can reduce stigma and isolation associated with having two parents of the same gender by using gender-neutral terms when taking a history, discussing which parent to contact when the student is ill or injured and updating forms for emergency contacts, administration of medication and permission to share medical information. School nurses can influence how school forms that are not health-related can be modified with gender-neutral terms. The wide variety of family constellations (in addition to lesbian and gay parent families) is better acknowledged by using “parent/guardian” on school forms instead of “mother” and “father.” (Mattey, 2012).

School nurses, as members of the coordinated school health team, are responsible for a safe school environment and should be actively involved in improving the safety of the school environment for all students including sexual minority students and students with sexual minority parents. They should participate in advocating for, creating, and enforcing policies about name calling, bullying and violence based on actual or perceived sexual minority status of both the students and their parents. School nurses are uniquely positioned to model respect for diversity, provide confidential health services for sexual minority students in a safe environment, and reduce stigma for students with gay or lesbian parents.

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Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that standardized nursing languages (SNL) are essential communication tools for registered professional school nurses (hereinafter, school nurses) to assist in planning, delivery, and evaluation of quality nursing care. SNL help identify, clarify and document the nature and full scope of quality school nursing practice (i.e., nursing diagnoses, interventions and outcomes). There are four main reasons that SNL are essential in school nursing documentation. SNL provide a common language, contribute to quality of care, enable continuity of care, and support research (Denehy, 2010). SNL enable communication about the contribution of professional school nursing practice to the health and academic success of students.

NASN supports the use of SNL in school nursing practice, electronic health records (EHR), and school nursing education programs. NASN further supports the continued research and development of SNL to advance evidence-based, quality school nursing practice.

HISTORY

The development of SNL began more than four decades ago. There are currently twelve terminology sets that support nursing practice approved by the American Nurses Association (ANA, 2012). They are:

- NANDA International (NANDA-I)
- Nursing Interventions Classification (NIC)
- Nursing Outcomes Classification (NOC)
- Clinical Care Classification System (CCC)
- The Omaha System
- Perioperative Nursing Data Set (PNDS)
- International Classification for Nursing Practice (ICNP)
- Systemized Nomenclature of Medicine Clinical Terms (SNOMED CT)
- Logical Observation Identifiers Names and Codes (LOINC)
- Nursing Minimum Data Sets (NMDS)
- Nursing Management Minimum Data Sets (NMMDS)
- ABC Codes

Five of the terminology sets include nursing diagnoses, interventions and outcomes (i.e., CCC; ICNP; a combination of NANDA-I, NIC and NOC; the Omaha System; Perioperative Nursing Data Set). SNOMED CT allows for the use of multiple nursing language sets in a standardized format within an electronic health record. Also, with SNOMED CT, all of the ANA approved terminology sets can be mapped to accommodate NANDA-I, NIC and NOC.

While there are a number of nursing languages that have been approved by the ANA, NANDA International (NANDA-I), Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) are probably the best known, well developed, and most applicable to school nursing practice (NANDA-I, 2011; Moorhead, Johnson, Maas & Swanson, 2008; Bulechek, Butcher, & Dochterman, 2008). The NASN publication, *Using Nursing Languages in School Nursing Practice, 2nd edition* by Janice Denehy, PhD, RN, FNASN, summarizes the history and development of the three nursing classifications. The North American Nursing Diagnosis Association began in 1973 when nurse experts from the United States and Canada came together to identify and classify health problems within the domain of nursing.

NIC started in 1987, and NOC followed in 1991 (Denehy, 2010). In 2002, North American Nursing Diagnosis Association changed its name to NANDA International (NANDA-I) to reflect the growing involvement of nurses from many overseas countries (Jones, Lunney, Keenan, & Moorhead, 2010).

NANDA-I, NIC, and NOC are recognized as official nursing languages by ANA (2012) and are included in the Cumulative Index of Nursing and Allied Health Literature and the National Library of Medicine's Metathesaurus. The NANDA-I, NIC and NOC classifications represent the nursing process, are supported by research, and facilitate continuity of care across the entire health care infrastructure.

DESCRIPTION OF ISSUE

The ANA (ANA, 2012) and NASN support the development and use of SNL to communicate the increasingly important role of nurses in health care, to promote research, and to provide the standardized terminology needed for use in EHR. Use of SNL in school nursing documentation provides a common language for school nurses to describe interventions and responses of their students and staff to those interventions. Without SNL, school nursing documentation is a personal or locally understood description of activities, and the words have different meanings for different readers. Therefore information cannot be translated or applied to other settings.

Important data is collected everyday in school health rooms and recorded in school health records. Increasingly the data is stored in EHR (NASN, 2009) which can enable meaningful use (MU) of EHR whereby electronic data can be used for exchange of information across care settings to improve quality and coordinated health care for clients. MU of EHR standards are outlined in the Health Information and Technology for Economic and Clinical Health Act of 2009 (HITECH), a law designed to improve quality and coordination of health care in the United States (Johnson & Bergren, 2011). Electronic school health data can contribute to the goal of HITECH, but first, to be meaningful, the data must be collected using SNL.

With SNL, standardized interventions are implemented and evaluated using standard outcome measures. Then data sets will emerge describing the work of school nurses (Jones, Lunney, Keenan, & Moorhead, 2010). Data sets are critical tools for research to identify many things that school nurses do to influence student health and achievement. NASN supports the use of the Nursing Minimum Data Set (NMDS) as the initial structure to identify data needed to describe care provided to students and characteristics of those students.

There is no national clinical school health database to support research to build evidence-based health services programs for schools. Analysis of data from school nursing documentation from across the United States can generate the elements for such a database. However, In order for the information collected daily in school health offices to be transformed into a useful database, the data must be organized in a standardized format that lends itself to comprehensive reporting and analysis (Johnson, Bergren, & Westbrook, 2012). SNL is a critical first step in MU of EHR, in establishing a national clinical school health database and in supporting school nursing research.

SNL enables ongoing retrieval and analysis of documentation over time to support evidence-based practice and quality nursing care. In analyses of documentation in standardized format, interventions are known and patient responses are understood. Information can be collated and compared by researchers to determine which interventions in a specific situation lead to quality outcomes. Nursing research using the data can provide evidence for school nursing practice as it relates to cost effectiveness, student health outcomes, and the overall impact of nursing within the schools.

RATIONALE

The use of SNL in school settings:

- Provides the structure for quantifying school nursing practice (Lee, Park, Nam & Whyte, 2010).
- Communicates elements of school nursing practice within the EHR (Jones et al., 2010).
- Supports two goals of the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine Consensus Report (2010):
 1. Nurses should be full partners, with physicians and other healthcare professionals, in redesigning health care in the United States.

2. Effective workforce planning and policy making require better data collection and information infrastructure.

- Provides accurate data on the value, role and necessity of school health services (Johnson et al, 2012).
- Advances nursing knowledge through identifying and evaluating nursing care (Rutherford, 2008).
- Promotes research on the effectiveness of school nursing services, leading to evidence-based practice which can improve patient care (Jones et al., 2010).
- Assists in determining actual costs of school nursing services for resource planning.
- Facilitates reimbursement for school nursing services.
- Supports the scope and standards of school nursing practice which specify the use of the nursing process in the planning, implementation, and evaluation of nursing care and the use of standardized languages in documentation (ANA & NASN, 2011).
- Supports nursing education, research and administration (Rutherford, 2008).
- Supports advocacy for school nursing.
- Communicates the contributions of school nursing practice to all stakeholders, including parents, education leaders, legislators, and community leaders.

Through use of SNL, school nurses promote quality nursing care, validate the effectiveness of school nursing services, and enable data collection for research. NASN supports continued school nurse contributions to the development, implementation, and evaluation of nursing languages relevant to school nursing practice.

NASN believes that use of SNL and research using the data collected from school nursing documentation will provide evidence to link school nursing interventions to quality outcomes for students.

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National Association of School Nurses

POSITION STATEMENT

State School Nurse Consultants

HISTORY:

State School Nurse Consultants (SSNC) are employed in 40 states (as of January 2004) either through the state health agency, the state education agency, or a combination of both. Many positions are supported through health funding money coming to states in areas such as Safe and Drug Free Schools, Coordinated School Health, health education, special education, or nutrition; others are funded directly from state budgets. States without a SSNC may have someone from another discipline in a position that serves as a liaison to school nurses within the state and represents health services at state-level meetings. These individuals would be unable to engage in activities such as interpretation of state nurse practice acts and initiating and coordinating quality assurance for school nurse programs.

DESCRIPTION OF ISSUE:

As school nursing becomes more specialized and health issues of students become more complex, it is increasingly crucial that school nurses have state-level school nursing leadership. This will ensure appropriate and timely information on changes in nurse practice and on medical, legal, and legislative issues being available to school nurses. Besides monitoring, informing, and consulting in these areas, a nurse at the state level can influence policy development by participating in state-level multidisciplinary partnerships.

State School Nurse Consultants can assist school nurses to advance their practice in the seven roles of school nursing. These roles are:

- Providing direct health care to students and staff
- Providing leadership for the provision of health services
- Providing screening and referral for health conditions
- Promoting a healthy school environment
- Promoting health
- Serving in a leadership role for health policies and programs
- Serving as a liaison between school personnel, family, community, and health care providers (NASN, 2002)

RATIONALE:

School nursing is a specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. School nursing is critical to the success of the school mission. However, in the independent practice setting of a school district, school nurses are often isolated from other health professionals. Additionally, their expertise varies as nurses enter the school nurse specialty from a variety of educational and work backgrounds. Just as standardization does not exist among school nurses, neither does it exist among school districts. Within the same state there may be many differences in school district policies and guidelines. Local supervision of school nurses is often limited and comes from an administrator with a background in education or personnel management, not nursing and health care. School nurses and school nurse administrators need statewide quality standards for school health policies, nursing procedures, health records, and quality assurance. Guidance and consultation from a school nurse consultant at the state level can assure this.

CONCLUSION:

It is the position of the National Association of School Nurses that a qualified State School Nurse Consultant should be employed in every state to provide guidance in school health services program development and planning; establish a continuum of staff development to include orientation and continuing education; and serve as a liaison and resource expert in school nursing practice and school health programming. School nurses can prepare to advocate for this position in their state by developing a plan in conjunction with the state school nurse organization and other key partners; writing a report on school nursing programs and their supervision; seeking assistance from a SSNC in a neighboring state; and reviewing the SSNC job description available on Web sites.

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National Association of State School Nurse Consultants. (NASSNC). www.nassnc.org

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Revised: July 2004



National Association of School Nurses

Position Statement School Nurse Supervision/Evaluation

SUMMARY OF THE POSITION:

It is the position of the National Association of School Nurses (NASN) that supervision and evaluation of school nurses based upon standards of professional school nursing practice is essential.

HISTORY:

Historically, school nurses were rarely or ineffectively evaluated by supervisors who had little or no knowledge and understanding of the school nurse role. School systems began including professional support personnel in their evaluation process in response to both public pressure and state mandates. The National Association of School Nurses responded to the need for an evaluation tool for school nurses by first developing, *An Evaluation Guide for School Nursing Practice: Designed for Self and Peer Review* to be used in conjunction with the 1983 edition of, *Standards of School Nursing Practice*. More recently, *Job Performance Evaluation Guidelines for School Nurses* was developed (Ackerman, 1995). Most current is the publication of *School Nursing: Scope and Standards of Practice*, jointly published by the National Association of School Nurses and the American Nurses Association in 2005.

DESCRIPTION OF ISSUE:

In order to meet students' health needs and to function effectively with school and community team members, School nurses need supervision and evaluation to maintain and improve competence in this independent practice. School nurses have the right to performance evaluations that promote excellence in school nursing practice (Tustin, et al., 2002). Best practice requires that this supervision and evaluation be performed by a registered professional School nurse.

A distinction needs to be made between supervision in the context of employee performance and employment law and supervision in the context of nursing practice and nursing law. In the employment context, supervision may include responsibility to direct or oversee, hire and fire, adjust salaries, or ensure a performance evaluation is done, even though direct input may come from sources other than the supervisor. In the nursing context, supervision is related to the scope of nursing practice as defined by the state's nurse practice act (Schwab & Pohlman, 2002). It is likewise necessary to "educate school administrators in regard to the laws that regulate school nurse practice" (NASN, 2006a)

RATIONALE:

School nurses are accountable through licensure, under nurse practice acts, for nursing judgments and actions. However, functions performed by school nurses that do not require a nursing license fall under the non-nurse supervisor's authority as outlined by the employer (Schwab & Pohlman, 2002).

Individual school nurse performance may be enhanced through development of a professional portfolio and/or evaluation of competencies as a part of a performance evaluation. With a professional portfolio featuring current

practice and a working plan for professional growth, School nurses are accountable for achieving their own learning objectives and enhancing their own practice (Trossman, 1999; Oermann, 2002). Competencies

- provide direction about what is needed to practice as a school nurse.
- depict the knowledge, skills, and attitudes necessary for the school nurse
- provide a way to measure professional growth, and
- furnish a framework for performance appraisal (Bobo, Adams, & Cooper, 2002).

Evaluations should be formalized and occur at regular intervals to assess both the professional and the program development of the school nurse. In districts without school nurse administrators, self-evaluation through use of an individual portfolio and assessment of competencies or by contracting with a school nurse supervisor in another school district for the nursing component of an evaluation is recommended. School nurses without nurse administrators can take a leadership role in assisting their administration in developing a tool that includes the non-nurse component and self-evaluation component of the performance evaluation.

CONCLUSION:

Enhanced student health and safety and continuous improvement of individual school nursing practice is the ultimate goal of supervision and evaluation (Tustin, Canham, Berridge, Braden, & Starks, 2002).

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Position Statement

SUMMARY

Telehealth has been defined as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration” (United States Department of Health and Human Services [USDHHS], n.d.). Telehealth enables collaboration of healthcare professionals to provide healthcare services across a variety of settings. The registered professional school nurse (hereinafter referred to as a school nurse) uses clinical knowledge and judgment to provide health care to students and staff, perform health screenings and coordinate referrals to the medical home or private healthcare provider (Wolfe, 2013). The school nurse serves in a pivotal role to provide expertise and oversight for the provision of school health services, promotion of health education, and connection between the academic setting and healthcare settings. Therefore, the school nurse is a critical link to the successful implementation and use of telehealth technology.

It is the position of the National Association of School Nurses (NASN) that telehealth technology may be used to augment school health services but not replace in-person health care provided by the school nurse.

HISTORY

The world has become increasingly reliant on a variety of technologies to manage information needs. Technology is “revolutionizing the way that health care is delivered with a steady infusion of new solutions to clinical environments” (Healthcare Information and Management Systems Society [HIMSS], 2011 p. 3). “Nurses have already taken a leadership role in embracing technology as a necessary tool to innovate the delivery of health care” (HIMSS, 2011, p. 2). School nurses need to be aware of and utilize telehealth when available to facilitate the delivery of health care in the school setting.

School-based telehealth includes using telephones, teleconferences, or web cameras in the school to connect to a distant healthcare provider. More sophisticated electronic monitoring equipment can be used in telehealth, such as an otoscope that transmits the image to a remote provider or stethoscope that transmits sounds with the goal of connecting a student with a distant health provider (The Children’s Partnership, 2009). Some school systems are experimenting and finding success with telehealth programs to extend the range of services in school health and decrease absenteeism for illness or disease-management encounters (Spooner& Gotleib, 2007).

DESCRIPTION OF ISSUE

The use of telehealth is “increasing access to acute and specialty care for children; helping children and families manage chronic conditions; facilitating health education for children, families and school personnel; and increasing the capacity of school nurses and school-based health centers to meet the healthcare needs of students” (The Children’s Partnership, 2009, p. 2).

Telehealth includes a wide range of services delivered, managed, and coordinated by all health-related disciplines via exchange of electronic information and telecommunications technologies. The goal is that “telehealth (a term that has largely replaced *telemedicine*) will provide health care beyond diagnosis and treatment to include services that focus on health maintenance, disease prevention, and education” (Stokowski, 2008, p. 1). Telehealth includes both clinical and non-clinical uses. Examples of clinical telehealth are transmission of medical images for diagnoses, remote monitoring, and health advice by telephones such as telerriage. Non-clinical telehealth includes distance education, health system integration, online information, and health data management (Stokowski, 2008).

Telehealth clearly has the potential to enhance health care of all students. Families in rural or low-income areas often face barriers and challenges in obtaining healthcare services for youth because of “travel distances, lack of transportation, inability to finance care, lack of healthcare insurance, and limited access to physicians. The use of telehealth in schools mitigates some of these difficulties and allows students access to medical care” (Burke, Ott, Albright, Bynum, & Hall-Barrow, 2008, p. 927).

The challenges related to telehealth technology include quality of service, confidentiality, standards, documentation process, protocols, follow-up, parental rights, liability, jurisdiction, and cost to implement and access equipment, school policies, and coordination of services. Therefore, school nurses must partner with the regulatory and professional agencies to implement, develop and use standards for safe and effective telehealth practice. Telehealth is emerging as a valuable way to “complement and expand the capacity of schools to meet the healthcare needs of children, particularly those who are low-income and living in medically underserved areas, while keeping them in school and their parents at work” (The Children’s Partnership, 2009, p. 2).

RATIONALE

Student health and educational performance are highly interdependent. It is well documented that healthy children perform better in school; therefore, school nurses have an important role in promoting the health of children (Bonaiuto, 2007; Engelke, Guttu, Warren, & Swanson, 2008).

Technology, including telehealth, has the potential to greatly expand the services provided by the school nurse but cannot and should not replace the school nurse. School nurses need to keep current with modern technology to support and enhance their clinical practice. The school nurse serves as a liaison between students, school personnel, family, community and healthcare providers to advocate for health care and a healthy school environment (American Nurses Association (ANA) and National Association of School Nurses (NASN), 2011) and the school nurse’s involvement is critical in the application of telehealth technology in the school setting (The Children’s Partnership, 2009).

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Please also see NASN's Position Statement on The Role of the School Nurse

<http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/87/Role-of-the-School-Nurse-Revised-2011>

Unlicensed Assistive Personnel-

The Role of the School Nurse

Position Statement



SUMMARY

It is the position of the National Association of School Nurses that the use of unlicensed assistive personnel (UAP) to perform delegated nursing tasks in the school setting is appropriate only if the school nurse is in control of the decision to delegate a health care task and a registered professional nurse conducts the training and supervision of UAP.

HISTORY

School nurses have traditionally been charged with providing health services in the school setting in order to reduce the spread of communicable diseases and promote health-protecting practices (Vessey & McGowan, 2006). As schools struggle with large student populations and budgetary demands, the provision of school health care in some areas of the country has seen a shift from a model where the school nurse provides direct care to students to supervising health care tasks performed in the schools by UAP (Gordon & Barry, 2009).

DESCRIPTION OF THE ISSUE

Unlicensed Assistive Personnel (UAP) are trained to assist the registered nurse in providing health care tasks in the school setting as delegated by the school nurse. UAP can make valuable contributions in the school setting by providing health care support in accordance with school nurse training and oversight, but it is vital that all members of the school community fully understand the legal roles and responsibilities of the UAP. School administrators have responsibility for student safety, but they are not qualified or legally allowed to determine what specific health care assistance is needed by a student (Hootman, 2006). The school nurse is the professional accountable for assessing the individual student health care needs and determining the capability and competence of UAP to provide appropriate care for the student (Resha, 2010). The safe delivery of health care is ensured when the orientation and training of UAP is a responsibility of the school nurse (Gursky & Ryser, 2007).

RATIONALE

NASN fully supports the employment of professionally prepared registered nurses to conduct and supervise school health programs, and recommends a formula-based approach with minimum ratios of nurses-to-students, depending on the needs of the student population. The school nurse is the singular health care professional in the school setting to provide leadership in the provision of evidence-based practice and health care task assignment when coordinating care for students (Spriggle, 2009). The role of UAP in the school setting has expanded as advances in medical technology and the increased integration of students with complex, specialized healthcare needs in the classroom have occurred. Nearly 20% of children and adolescents have a chronic health condition, and almost half of those students could be considered disabled (Perrin, Bloom & Gortmaker, 2007). Federal law mandates that all students, regardless of medical needs, be allowed to attend school and receive a free and appropriate public education (*Cedar Rapids Community School v. Garrett F.* 1999). Currently, as schools are looking at ways to address budgetary concerns and a general economic downturn, the use of UAP in school health offices

is expected to increase (Gordon & Barry, 2009). The school nurse needs to know and follow the principles of nursing delegation (ANA, 2005; ANA & NCSBN, 2006) and the laws of education and special education to ensure the delivery of safe and appropriate healthcare in the school setting.

In addition, State Nurse Practice Acts, as well as legal and regulatory guidance, contain developed state specific parameters to avoid inappropriate and illegal delegation of health care tasks, which could potentially result in an individual practicing nursing without a license. Individuals that violate these laws may be subject to civil and/or administrative prosecution (ANA/NCSBN, 2005).

Recommended qualifications for UAP include (NASN, 2005):

- Education (e.g., high school diploma or higher; first aid and CPR certificate; prior health experience; other pre-employment training per school district policy),
- Personal attributes (e.g., willing to assume responsibility for assigned tasks; works within job description; understands and follows directions from the school nurse; possesses common sense),
- Interpersonal attributes (e.g., maintains confidentiality of information; communicates clearly; enjoys working with children), and
- Emergency effectiveness (e.g., remains calm and demonstrates good judgment when the unexpected occurs; knows how and when to call emergency medical services and/or the school nurse).

Role and responsibilities of UAP include (NASN, 2005):

- Maintain competence to perform the delegated task,
- Ask questions if directions are not understood,
- Follow directions and guidelines provided,
- Communicate concerns promptly,
- Report observations and activities to the delegating school nurse, and
- Document the provision of care as directed.

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The Use of Volunteers in School Health Services



Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that quality health care within the school environment can best be attained through the employment of a full-time registered professional school nurse (hereinafter referred to as school nurse) for each school building. The health services needed by students at school continue to evolve in complexity and quantity increasing the need for the advanced knowledge and skills of the school nurse. While volunteers, licensed or unlicensed, may be needed to assist the school nurse, they must never act in the place of the school nurse.

HISTORY

Many schools use volunteers to assist the school nurse in providing health services. Volunteers may range from licensed healthcare providers to lay individuals, including parents and senior citizens. As a result of diminishing resources, some schools are utilizing volunteers in the absence of a full-time school nurse to meet the health office needs. Using volunteers as the only staff in the health office decreases the financial burden on the school, but it also increases the school's liability by providing suboptimal health services that are often outside of the legal parameters defined by each state (American Nurses Association [ANA], 2012).

DESCRIPTION OF ISSUE

Using volunteers to provide health services at school requires that school policies and school nurse oversight are in place to ensure the health and safety of the students served and to mitigate potential school liability. The school nurse has specialized knowledge and skills in assessment, communication between the school, medical and family communities, emergency planning and the care of chronic and acute conditions. These are essential to provide health care effectively to those in schools and to ensure coordinated care during school hours (American Academy of Pediatrics [AAP], 2008). When volunteers are utilized to provide care, the school nurse remains accountable for the decision to include a volunteer in providing health services. The school nurse's responsibilities include training this individual, verifying the competency of the volunteer to complete the assigned tasks (Hootman, 2013) and providing ongoing supervision to ensure continuity of care and appropriate communication between the school, family and healthcare provider (ANA, 2012). Furthermore, when a student's healthcare needs require special school accommodations, it must be the school nurse (not the volunteer) who is a member of the IEP and/or 504 teams (AAP, 2008).

Confidentiality within the school environment is essential, whether it relates to interactions with healthcare providers or maintaining and protecting health records. Volunteers may inadvertently breach confidentiality. Should this happen, it could prevent or destroy the trusting relationships which are essential to providing health care for students and ensuring their safety while at school. The Family Educational Records and Privacy Act requires that policies and procedures be followed for the distribution of health information and defines who legitimately has an educational interest in the child (U.S. Department of Education, 2011).

If volunteers are utilized to deliver health care in the school setting, the volunteers should:

- Follow the district policies and procedures;
- Meet state requirements for delivery of care;

- Receive an orientation to the health office;
- Complete health trainings required by the school district (e.g., universal precautions, emergency care for students with diabetes);
- Understand the HIPAA and FERPA confidentiality laws;
- Complete and sign a confidentiality agreement;
- Complete CPR/ First Aid certification;
- Understand the school's plan for disaster preparedness; and
- Demonstrate willingness and competence in providing the assigned health tasks.

When making a decision to use volunteers, it is important that school districts, the supervising nurse and those volunteers who hold licensure (RN's, LPN's and APRN's) realize that they are held to the level of their licensure. They cannot volunteer and function as a UAP. They are held and must function to the level of their degree. Licensed volunteers cannot function as a UAP unless they have allowed their license to go inactive. Volunteers may not be covered by the school district's insurance, and there is serious doubt that malpractice insurance would cover a nurse working outside his/her job description (M.D. Bergren, personal communication, April 9, 2012).

Criminal background checks, finger-printing, immunizations, tuberculosis and drug screenings may be required of volunteers if they are also required of other staff within the school. School districts that utilize nurse volunteers must comply with the Nurse Practice Act for that state. For some states this will mean that they must have an active nursing license even to volunteer. School districts will need to investigate liability protection and Workers' Compensation for volunteers as well. Safety, nursing practice and liability concerns may ultimately outweigh the advantages of using volunteers.

RATIONALE

The American Academy of Pediatrics (AAP) (2008) notes that a full-time school nurse is associated with better student outcomes and recommends that a school nurse be physically present in the school. This is due, in part, to the increasingly complex health services which require the advanced skills of the school nurse for their implementation in the school setting (Maughan & Adams, 2011). The reality of today's healthcare/school environment and the resulting demands placed on the school nurse may include using volunteers to provide health services at school. While volunteers may be used to assist in providing health tasks at school if allowed by the nurse practice act of the state, the school nurse remains responsible and accountable for the outcomes (Anthony & Vidal, 2010; ANA, 2012). Therefore, using volunteers ultimately requires the employment of a professional school nurse.

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National Association of School Nurses

ISSUE BRIEF

School Nurse Role in Education

School Nursing Services in Alternative Education Programs

INTRODUCTION

All students are entitled to an educational program that meets their unique needs. When students require a setting or instruction different from their classmates in order to learn, they may be placed in an alternative program where their needs can be better addressed. A change in their educational setting, which is separate from the general student population, should not reduce their access to school nursing services. Their needs must be addressed within comprehensive health services planning for the total school population.

BACKGROUND

In the United States, alternative high schools serve approximately 280,000 students who are at high risk of dropping out of regular high school or have been expelled because of illegal activities (Centers for Disease Control [CDC], 1999). Alternative education is often established for the following groups: women/girls, pregnant/parenting teens, suspended/expelled students, recovered drop-outs, delinquent teens, low-achievers, and all at-risk youth.

Alternative education programs are located in many different places. Examples of locations include: regular schools during school hours, school buildings during non-school hours, former school buildings, community or recreation centers, public housing projects, homeless shelters, medical or mental health facilities, community college campuses, and store-front neighborhood organizations. Access to school nursing services may be limited in those settings outside of school district buildings.

Many alternative education programs have different policies and administrative procedures than those typically found in regular education programs. Most programs schedule academic instruction around students' apprenticeships or other employment. The National Association of State Boards of Education says students in successful programs have improved grades, school attendance, and graduation rates; less disruptive and violent behavior; fewer suspensions; and improved direction and sense of self (Aron, 2003).

The No Child Left Behind Act of 2001 (NCLB), the latest revision of the Elementary and Secondary Education Act (ESEA), mandates that all students educated within each state shall meet the same academic standards regardless of setting or educational program. In addition, each state must show coordination between NCLB and other programs such as the Carl D. Perkins Vocational and Technical Education Act of 1998 and the McKinney-Vento Homeless Assistance Act (Department of Education, 2002a).

With the 1997 Amendments to the Individuals with Disabilities Education Act (IDEA) (PL 105-17), the mission of alternative programs has expanded. Now, in addition to providing an education for students who dropped out of their general education program, or who were at risk of dropping out, the programs include students with disabilities whose behavior warrants special attention outside the general education setting. Students with disabilities have unique needs beyond those of non special education students. Special education students in alternative programs require seven essential elements for effective programming. One of these elements is identified as appropriate staff, resources, and procedural protections for students with disabilities (ERIC Digest, 1999). The NCLB allows local educational funding to be used for alternative education programs as well as for programs to hire and support staffing for school nurse services (Department of Education, 2002b).

RATIONALE

Many students who attend alternative high schools are involved in behaviors that place them at risk for serious health problems. A comparison of the Alternative High School Youth Risk Behavior Survey to the Youth Risk Behavior Survey demonstrates students attending alternative high schools are significantly more likely to have smoked cigarettes, consumed alcohol, used marijuana, used cocaine, or carried a weapon (CDC, 1999). Of particular concern is the fact that nearly 48 percent of students used at least one substance on school property and 17 percent used more than one substance on school property during the 30 days preceding the survey (Brener & Wilson, 2001). In addition, students attending alternative high schools were significantly more likely to have participated in a physical fight, never or rarely worn a seat belt, driven after drinking alcohol, ever had sex, had four sexual partners, and had sexual intercourse during the three months preceding the survey. No significant difference existed between the two groups in regard to those who thought they were overweight or who were enrolled in a physical education class (CDC, 1999).

In order for students in alternative settings to meet the rigorous educational criteria now established for all students under NCLB, it is more critical than ever that health concerns that impede their learning be addressed. These students urgently need prevention and treatment programs to help them live in safer environments (Escobar-Chaves, Tortolero, Markham, Kelder, & Kapadia, 2002). Schools are in a position to provide programs to help decrease the prevalence of risk-taking behavior (Grunbaum, Lowry, & Kann, 2001). Unfortunately little research exists regarding types of intervention programs and services available for students who attend alternative schools. However, characteristics of programs that have been effective in reducing health-risk behaviors are known. These include a comprehensive, multidisciplinary focus on risk factors, individual student attention, school-community teams providing integrated services, and community-wide approaches (CDC, 1999). School nurses, as members of the school-community multidisciplinary team can provide a number of supportive services. Fortunately, NCLB legislation allows school districts to hire and support school nurses.

ROLE OF THE SCHOOL NURSE

The school nurse provides both early identification and effective intervention, along with care management and referral, and can effectively assist the multidisciplinary team to address the health-related issues facing students in alternative educational settings. The school nurse is an essential member of the school multidisciplinary team in advocating for the student's health needs. School nurses develop individualized healthcare plans (IHPs) and emergency care plans (ECPs) for students as indicated.

In meeting the complex health issues of students in alternative educational programs, school nurses are in a position to assess the needs of the student population and build collaborative partnerships for funding and service provision with community providers. Such partnerships will serve to increase the quality of care provided to students in the school program while decreasing funding and staffing demands on the school district. To be most successful, ongoing dialogue with school staff and community providers is necessary (Newfield & Johnson, 2001).

Considering the high level of tobacco, alcohol, and substance use and abuse by students in alternative education, substance abuse and smoking cessation programs are areas in which partnerships can be established. Community programs geared toward adolescents (not adults) should be in a position to evaluate programs that best meet the various needs of adolescents (Donovan, 2000). Another area of concern with this population is the risk of sexually transmitted diseases. Again, community programs may provide educational assistance (Marick, 2002).

School nurses are key members of the school/community team in planning and supporting accommodations for pregnant and parenting adolescents. This group of young women needs supportive assistance to achieve success and fulfillment in their roles as mothers, individuals, and members of society. According to the National Coalition on Women and Girls in Education (2000), adolescent girls most often cite pregnancy and parenting as the reasons they drop out of school.

School nurses can play a part in helping adolescent mothers overcome the negative consequences of early childbearing, such as poverty, incomplete education, unemployment, and offspring at risk for a variety of social and behavioral problems. Because enrollment in school and school attendance are predictors of achievement, school nurses and the school multidisciplinary team, along with community agency personnel, can assist in keeping this vulnerable population in the educational system (Spear, 2002; Casserly, Carpenter, & Halcon, 2001). School nurses can encourage the school community to support parenting adolescents through provision of child care while they attend school.

Considering the potential for violence with some students in alternative education programs, school nurses serving these programs should consider their responsibilities and roles in disciplinary matters. School nurses should become knowledgeable about the school district discipline requirements and procedures in alternative education programs and report violations. They can help in determining if a student's disability caused or contributed to misbehavior due to a medical diagnosis or medication. School nurses can also assist the administration in keeping disciplinary policies current and responsive to school community needs (Gelfman, 2002).

School nurses enhance the education of students entitled for special education services within the alternative education program through participation at Individualized Education Plan (IEP) meetings. Additionally, school districts may be eligible for billing Medicaid for direct health services provided to qualifying students by school nurses and the unlicensed assistive personnel to whom they delegate personal health procedures.

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November 2003

Care in Extended School Year, Before and After School Programs and The Responsibilities of the School Nurse: *A School Nurse All Day, Every Day*



Issue Brief

INTRODUCTION

The White House Task Force on Obesity (May, 2010) called for an increase in access to programs encouraging supervised and safe physical activities beyond the school day. Research continues to support the premise that students who receive adult supervision and additional learning opportunities outside of the traditional school day show improved academic achievement, are less likely to engage in drug use behaviors, and have a better attitude toward school. Students continue to have the same health, nutrition, and safety needs as addressed by the school nurse during the traditional school day. Local educational agencies, schools, and teachers should include considerations for ensuring physical activity for students with disabilities in their Individualized Education Plans (IEPs), including extended school year programs. Extended and before and after school programs that are a part of the school system should, at a minimum, engage the school nurse to act in an advisory capacity to address these student needs (Afterschool Alliance, n.d.).

BACKGROUND

Each afternoon across the U.S., 15 million children--more than a quarter of our children--are alone and unsupervised after school. The parents of 18 million would enroll their children in an after school program if one were available. These are some of the key findings from *America After 3PM* sponsored by the JCPenney Afterschool Fund, the nation's most in-depth study of how our children spend their afternoons. The 2009 report, conducted for the Afterschool Alliance, surveyed nearly 30,000 households across the United States. Parents of after school program participants recognize that after school programs are more than just safe places for kids. According to these parents, the top benefits of participation include helping with social skills, keeping kids safe, providing opportunities to be physically active, and helping their child succeed in school (Afterschool Alliance, 2009).

RATIONALE

The Center for Disease Control's 2009 report on school connectedness reports that improving students' health and education outcomes by improving connectedness to school is a large undertaking that requires efforts not only of those within school buildings but also of people and organizations outside of schools. The report calls for community partners to provide a range of services at schools that students and their families need (e.g., dental services, health screenings, child care, and substance abuse treatment). In the school setting coordinating these services is clearly the role of the school nurse. A study measuring the health and social benefits of afterschool programs found when controlling for baseline obesity, poverty status, race and ethnicity -- that the prevalence of

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obesity was significantly lower for after school program participants (21 percent) compared to nonparticipants (33 percent) (Mahoney, Lord, Carryl, & Lawrence Erlbaum Associates, Inc., 2005).

Children who are left at home before and after school with no supervision may face the risks of unsafe neighborhoods, traffic, street violence, and encounters with strangers, both in person and online. Adolescents who “hang out” with other adolescents with too much free time may participate in anti-social behavior such as joining gangs, using drugs or alcohol, or engaging in premature sexual activity. Violent crimes by juveniles occur most frequently in the hours immediately following the close of school on school days (Office of Juvenile Justice and Delinquency [OJJJD], 2008). Rather than staying home alone unsupervised, it is in the best interest of students to attend quality childcare programs and in the best interest of communities to have such programs available. Health service needs of students must be addressed during alternative academic times such as extended school year as well as before and after school programs.

ROLE OF THE SCHOOL NURSE

Because on-site before and after school programs are on the increase and extended school year programs are offered to some students receiving special education services, school nurses will likely have such programs in their school districts. The Scope and Standards of Practice for School Nurses (American Nurses Association [ANA]/National Association of School Nurses [NASN], 2011) promotes a safe and healthy environment. The school nurse should function as both a resource and an advocate for health-related issues in the school setting - all day and every day. The staff planning and providing after school programs will need consultation on various medical concerns including first aid, CPR, recognition of signs and symptoms of child abuse and neglect, and procedures for protecting against blood borne pathogens. The school nurse should be engaged by program leaders to provide this consultation.

In the extended school year and before and after school programs in the school setting, the school nurse should explore the use of delegation to provide effective healthcare services. Delegation is defined as the assignment of the performance of a nursing activity to a non-nurse. Accountability remains with the registered nurse; state laws and regulations must be followed; and standards of school nursing practice must be upheld (American Nurses Association [ANA]/National Association of School Nurses [NASN], 2011). The implications of appropriate delegation of nursing tasks for school nurses center around four major themes: development of school policies, competence in the five rights of delegation, education, and relationship building (Resha, 2010).

When engaged by extended school year and before and after school program leaders, the school nurse can provide expertise on a variety of issues faced by school staff, including but not limited to:

- Maintaining confidentiality
- Management of chronic diseases, such as asthma and diabetes
- Management of health care for children with disabilities
- Management of allergy exposure and anaphylaxis
- Management of seizures
- Management of medication administration
- Management of communicable diseases
- Nutrition and food safety issues
- Mental health and substance abuse issues and referrals

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Environmental safety issues
Management of medical emergencies

The most common medical emergencies occurring in school programs are injuries, breathing difficulty from obstructed airway or asthma, seizures, and choking (Loyacono, 2005). Managing medical emergencies is an area in which the majority of teaching staff continue to lack appropriate educational preparation. Yet, literature recommends that staff working with children have a basic knowledge of first aid and CPR certification. Both staff and students participating in before and after school programs will benefit from preparedness to respond to a wide range of emergencies (American Academy of Pediatrics [AAP], 2008).

Successful integration of students who are dependent on medical technology requires a coordinated effort among the school nurse, educational staff, primary care physician, family, and, when appropriate, the student (Raymond, 2009). Because school nurses are the healthcare experts in their buildings, it is imperative that they be engaged by program leaders to take an active role in this process outside the school day as well as during the more traditional school day.

When engaged in extended school year and before and after school programs in the school setting, school nurses will advance the academic achievement of participating students by promoting the health and safety aspects of these programs. School nurses will further influence academic achievement by consulting with program staff so that they can intervene with actual and potential health problems experienced by the students in attendance.

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INTRODUCTION

Child maltreatment, formerly referred to as abuse and neglect, is a crime, a tragedy and a significant public health burden. In 2009, an estimated 3.3 million referrals to child protective services (CPS) alleged maltreatment of approximately 6 million children. Of those, 62% were screened and maltreatment was found to be evident in 24% of those children (USDHHS, 2010).

Neglect was and is the most common form of child maltreatment. Although any of the categories of child maltreatment may be found separately, they often occur in combination. According to the Child Maltreatment 2009 report (USDHHS, 2010), CPS investigations determined the following:

- More than 75% suffered neglect.
- More than 15% suffered physical abuse.
- Fewer than 10% suffered sexual abuse.
- Fewer than 10% suffered psychological abuse.

For 2009, more than half (58.3%) of all reports of alleged child maltreatment were made by professionals. The US Department of Health and Human Services, Children's Bureau, notes that a "professional" means the person had contact with the alleged child maltreatment victim as part of the report source's job. Of these professionals, the most common report sources were education personnel (16.5%), legal and law enforcement personnel (16.4%) and social services staff (11.4%) and medical personnel (8.2%). The remaining reports were made by nonprofessionals, including friends, neighbors, sports coaches and relatives (USDHHS, 2010).

BACKGROUND

The Child Abuse and Prevention and Treatment Act (CAPTA) originally passed in 1974 and amended by the CAPTA Reauthorization Act of 2010, defines child maltreatment as:

"Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation or, an act or failure to act which presents an imminent risk of serious harm." (CAPTA, 2011, p. 6).

A "child" under this definition generally means a person who is younger than 18 or who is not an emancipated minor. The importance of understanding individual state laws as it pertains to maltreatment of emancipated minors cannot be overlooked. Specific state laws may require reporting to other agencies. Situations concerning emancipated minors who are victims of maltreatment should still be reported to CPS where guidance can be offered regarding further reporting requirements.

Many states have extended definitions for maltreatment such as physical abuse, neglect, and emotional abuse not found in the CAPTA language. Abandonment and substance abuse by a parent or caretaking adult have also been part of the definition in some states. CAPTA does provide definitions for sexual abuse and for maltreatment where medically indicated treatment has been withheld. (Child Welfare Information Gateway, 2011).

All 50 states, the District of Columbia and the U.S. territories have mandatory child maltreatment reporting laws that require certain professionals and institutions to report suspected maltreatment to a CPS agency (USDHHS, 2010). Registered professional school nurses (hereinafter referred to as school nurse), as well as teachers and other school staff, are among those legally required to report suspected child maltreatment. If a mandated reporter does not report pertinent information within the legally required time period the reporter may be in violation of child protection and reporting laws. This violation may carry a fine or imprisonment for lack of due diligence (Child Welfare Services, 2011).

RATIONALE

Adverse childhood events have long term effects on the lives of adults, and this impacts our health care systems as well as the health of individuals in our communities. Early identification and intervention is crucial in preventing further victimization. Physical and emotional recovery cannot happen if the maltreatment continues. School personnel are often the first to become aware that a child is struggling because of adverse events occurring in his or her life. The effect of violence alone on a child increased the risk of appetite problems by 28%, headaches 57%, sleep problems 94% and stomachaches 174% (Shannon, Bergren & Matthews, 2010). Long term effects of adverse childhood experiences were studied by the Centers for Disease Control and Prevention (CDC, 2010).

The Adverse Childhood Experiences Study (ACE) identified 17 long-term health issues that were the result of childhood abuse or neglect. These health issues were clustered by the number of adverse experiences a person identified. The more events, the more long-term health issues there were (CDC, 2010). Therefore, it is vital that early intervention be emphasized and that school personnel receive training to recognize the signs of maltreatment when it is occurring.

Childhood maltreatment has been linked to long-term depression risk (Nanni, Uher & Danese, 2011). Childhood physical abuse has been associated with chronic fatigue syndrome (Fuller-Thomsen, Sulman, Grennenstuhl & Merchant, 2011). Childhood trauma has been linked to higher rates of mental health problems (Burke, Hellman, Scott, Weems & Carrion, 2011). Victims of child maltreatment are more likely to perpetrate youth violence and intimate partner violence (Fang & Corso, 2007). Sexual abuse survivors have increased risk of psychiatric disorders (Chen, et al, 2010).

ROLE OF THE SCHOOL NURSE

School nurses have the opportunity to interact with children on a daily basis. School nurses should be familiar with their respective state's child maltreatment reporting laws. The role of the school nurse is to report suspicion of abuse; the role of CPS is to investigate the suspicion. Not only is it a legal requirement, but reporting child maltreatment as well as taking appropriate action regarding instances of illegal, unethical, or inappropriate behavior that could endanger the best interests of children is within the scope and standards of practice of school nurses (American Nurses Association [ANA] & National Association of School Nurses [NASN], 2011). School nurses are accountable and responsible to:

- Identify students with frequent somatic complaints which may be indicators of maltreatment,
- Know policies and procedures of the school or district for the process of reporting,
- Support the victims of child maltreatment,
- Educate and support staff regarding the signs and symptoms of child maltreatment,
- Provide personal body safety education to students,
- Link victims and families to community resources, and
- Collaborate with community organizations to raise awareness and reduce incidence.

School nurses advance the academic achievement of students by protecting their health and safety. Additionally, school nurses consulting with school personnel promote the ability of faculty and staff to recognize suspicious indications of maltreatment and respond appropriately to keep students safe. School nurses need to be sensitive to patterns and injuries that indicate maltreatment and to stay current with the research, clinical practice, laws and regulations.

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This document replaces the following Position Statement:

Child Abuse and Neglect (Adopted: June 1974; Revised: June 1982, 1985, 1996, 2002, 2006)

Do Not Attempt Resuscitation (DNAR)



National
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School Nurses

Issue Brief

INTRODUCTION

Families today face many issues, but none more sensitive and emotionally challenging than an order for Do Not Attempt to Resuscitate (DNAR). A DNAR order is not abandonment of medical treatment and does not rescind any obligation to provide quality care; rather it is part of the management plan. This plan is reviewed by the healthcare provider with the family to communicate the difficult decision to refrain from life sustaining treatment that is determined by the healthcare provider and family to be ineffective or that the risks would outweigh the benefits. A DNAR medical order for the school should be implemented in the context of palliative care, including comfort measures, as well as addressing emotional and spiritual needs (AAP, 2010).

It is the position of the National Association of School Nurses (NASN) that each student with a DNAR order have an Individualized Health Care Plan (IHP) and an Emergency Care Plan (ECP) developed by the registered professional school nurse (hereinafter referred to as school nurse) with input from parents or guardians, the student's healthcare provider, the palliative care team, administrators, teachers, local emergency medical services, local funeral director and, when appropriate, the student in order to support the student's access to education and palliative health care. Furthermore, a Do Not Attempt Resuscitation (DNAR) order for a student should be evaluated individually at the district level with input from the school district's legal counsel for consideration of state and local laws.

BACKGROUND

In a 1974 statement, the American Heart Association declared that cardiopulmonary resuscitation (CPR) was not indicated for all patients. Individuals with terminal, irreversible illnesses where death is the expected outcome do not necessarily merit CPR. In 1994, the American Academy of Pediatrics (AAP) and the National Education Association (NEA) issued guidelines on foregoing life-sustaining CPR for children and adolescents (AAP, 2010). Originally, the medical order was referred to as a Do Not Resuscitate order (DNR), which evolved to Do Not Attempt Resuscitation (DNAR), and sometimes Allow Natural Death (AND) (Selekman, Bochenek & Lukens, 2013). Currently the order to provide comfort care is part of a much broader palliative care plan, which may include Medical Orders for Life Sustaining Treatment (MOLST) (APA, 2010). In the case of *ABC School v. Mr. and Mrs. M*, in Massachusetts, the court ordered the school to honor the DNAR order for a medically fragile child. In addition, the court refused to allow the school to shield staff from liability should they choose not to honor the DNAR order (Adelman, 2010).

Chronic health conditions that involve special healthcare needs impact an estimated 19.2% (14.2 million) school-age children (Bethell et al., 2011). The AAP (2010) estimates that on any given day, there are 2,500 adolescents and 1,400 preadolescents who are within 6 months of dying from their chronic condition, such as end stage heart, liver, kidney disease and cancer (Adleman, 2010). According to a Centers for Disease Control and Prevention survey, the percentage of schools where health services staff reported the need to follow a DNAR order increased from 29.7% in 2000 to 46.2% in 2006 (AAP, 2010).

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RATIONALE

Growing populations of students with chronic health conditions -- including terminal and irreversible illnesses, congenital defects, injuries, and malignancies, where death may be the expected outcome -- are now routinely attending school (Klick & Hauer, 2010; Adelman, 2010). Children with special healthcare needs are entitled to access a free and appropriate education in the least restrictive environment (U.S. Dept. of Justice, 2005). Whenever possible, students with chronic or terminal conditions belong in school in order to access their education. Students benefit from the psychosocial and emotional benefits of interacting with peers and maintaining their daily routine (Klick & Hauer, 2010). Because state and local laws and regulations vary regarding DNAR orders for students, each palliative care request must be reviewed by the school team, with leadership from the school nurse in order to provide the best care possible in the school setting for the student (AAP, 2010).

Care coordination in school is best led by the school nurse and starts with conversations with the parents/guardians, student and medical team, and receiving medical orders in order to develop the IHP and an ECP. The school nurse is the most qualified school staff person to ensure that a student with a DNAR is protected from ineffective or painful interventions and is kept comfortable and safe in school (Adelman, 2010).

ROLE OF THE SCHOOL NURSE

Development and implementation of the IHP is the responsibility of the school nurse and is supported by the AAP (AAP, 2008). The development of the IHP requires the school nurse to:

- Work collaboratively with the school team (the family, school psychologist, the school guidance counselor, administrators, teacher and members of school crisis teams).
- Coordinate plan with local EMS, funeral director, hospice providers and other local agencies where applicable.
- Be knowledgeable about state and local laws and regulations regarding DNAR orders.
- Communicate and coordinate the development of the school plan with all members of the student's health care team which may include the family, pediatrician, social worker, child life specialist, and palliative care team members (Klick & Hauer, 2010).
- Participate as an essential member of team in the development of the Section 504 plan or the IEP plan, communicating the plan and the IHP to school staff while maintaining student confidentiality to the extent requested by the student/family. This plan should be reviewed annually, if necessary.
- Coordinate emotional support for staff utilizing school district and community resources including bereavement services for the school community in collaboration with the palliative care team, school team and community mental health resources (Klick & Hauer, 2010).
- Provide support for school staff to address attitudes and cultural beliefs concerning death and dying in order for the student to have the optimum experience while at school.
- Support nursing research to develop evidence-based care for students in need of palliative care and a DNAR in school (Morgan, 2009).
- Provide clear, evidence-based information to school staff regarding the student's condition in terms school staff can comprehend.
- Recognize the importance of self-care during this process (Morgan, 2009).

Components of the IHP include but are not limited to:

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- A written DNAR request from the parent(s) as well as the healthcare provider's written DNAR order that are acceptable per state regulations. A court order may be required. (Selekman, Bochenek, & Lukens, 2013).
- DNAR information:
 - Acceptance of DNAR orders vary according to state regulations.
 - The DNAR request should have a clearly delineated date (some orders are rescinded while in hospital or otherwise. Many DNARs need to be reordered as deemed by the medical facility or state regulations). Some DNAR orders are issued for short periods of time and need to be renewed within a few weeks.
 - An original DNAR order or a copy of the order on the appropriate state EMS Palliative Care/DNAR order form may be required.
 - A state authorized Out of Hospital Do Not Resuscitate bracelet or necklace may also be accepted by Emergency Medical Services.
 - The DNAR order may be revoked at any time.
- Notification of EMS and medical examiner of DNAR orders for student in school.
- Specific actions that may and may not be performed by staff clarifying end of life issues versus acute episodes that may require treatment/ management vs. comfort care measures.
- Comfort measures which may include holding, positioning, oxygen administration, pain and bleeding control (Selekman, Bochenek, & Lukens, 2013).
- Determination of which staff members should be informed of and educated about the IHP and the DNAR order.
- Contacts in case of emergency (the parent, primary physician and prearranged notification with the EMS provider).
- Development of a code to which all staff will know how to respond.
- Where to move the student to provide student/family privacy.
- Who will do the pronouncement of death (physician, nurse practitioner or physician assistant). In some states, pronouncement of death becomes a concern in the school setting; i.e. the local EMS may not be able to remove the body if death has already occurred. If this happens, arrangements must be made as to who will arrive promptly to pronounce death so the body can be removed from the school as soon as possible.
- Transportation and mortuary arrangements.
- Plans for training and supporting staff and student's peers.

School nurses play a pivotal role with respect to DNAR orders as well as the delivery of health care (AAP, 2010; Klick & Hauer, 2010). In addition, the school nurse is the school professional with the knowledge, experience and skills to link the school with the medical and community services needed by the student while advocating for the student and family to ensure access to a free and appropriate education (Selekman, Bochenek, & Lukens, 2013).

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This document replaces the following Position Statement:

Do Not Resuscitate (Adopted: 1994; Revised: June, 2000; November 2004).

Issue Brief

INTRODUCTION

The use of illegal drugs throughout the nation is a serious problem affecting the health of the youth in America. Illicit drug use among adolescents, including the use of marijuana and prescription medications, is on the rise. In 2009, over 10% of youth, age 12 to 17, were current drug users, an increase of 0.7% from 2008 (Substance Abuse and Mental Health Services Administration [SAMSHA], 2010). Abuse of prescription drugs is on the rise and accounts for 8% of illegal drug use among adolescents (National Institute of Drug Abuse [NIDA], 2010). The 2009 National Survey on Drug Use and Health finds new users of prescription drugs now outnumber new users of marijuana (Office of National Drug Control Policy, 2010).

Adolescents have access to drugs in a variety of locations, which include but are not limited to school grounds. According to the *Youth Risk Behavior Survey* (Centers for Disease Control and Prevention [CDC], 2010), over 27.2% of students nationwide had been offered, sold, or given an illegal drug on school property during the preceding 12 months. The same survey indicated that 36.8% of students nationwide had used marijuana at least once, and 4.6% had used marijuana on school property more than once during the 30 days preceding the survey (CDC, 2010). These statistics are evidence of the continued problem with drug use among adolescents in the United States.

BACKGROUND

Random drug testing, often referred to as suspicionless testing, is allowed for use in the public school system by the Supreme Court for all middle and high school-age students involved in extracurricular activities (*Pottawatomie Cty. v. Earls*, 2002). Initially, courts only allowed public schools to conduct random testing on student athletes (*Vernonia School District v. Acton* 1995). The authority of public schools to test students for illegal drugs was broadened by the U.S. Supreme Court to test all students in extracurricular activities in June 2002 (*Pottawatomie Cty. v. Earls*, 2002). The school district involved in this 2002 Supreme Court case applied the practice to only competitive extracurricular activities that were sanctioned by the state secondary schools activities association including Future Farmers of America, Future Homemakers of America, band, choir, and cheerleading (*Pottawatomie Cty. v. Earls*, 2002).

There are professional organizations that disagree with the presence of random drug testing in schools. In 2007, the American Academy of Pediatrics (AAP) released an addendum to their original 1996 position statement on the issue. The AAP (2007) acknowledges the need for additional research on safety and efficacy of school and home-based testing, adolescent-specific substance abuse treatment resources to ensure appropriate referrals to rehabilitation, and the primary care physician should be the first contact by parents suspecting adolescent substance use. NAADAC -The Association for Addiction Professionals' 2010 position statement also questions the efficacy of school-based drug testing and whether a health care setting would be a more appropriate venue for drug testing.

The implementation of a drug testing program is a complex issue, and additional research is needed on the effectiveness of drug testing programs. (Goldberg et al., 2007). Careful planning, community needs assessments, and a well-rounded team of advocates for children are all necessary components of addressing drug use. Drug testing is a component of the assessment plan (NAADAC, 2010).

The National Association of School Nurses (NASN) supports community needs assessments surrounding substance abuse in schools and recognizes that some communities may choose to implement a random drug-testing program based on those assessment results.

RATIONALE:

Schools that have adopted random student drug testing are hoping to decrease drug abuse among students via two routes. First, schools that conduct testing hope that random testing will serve as a deterrent and give students a reason to resist peer pressure to take drugs. Secondly, drug testing can identify adolescents who have started using drugs so that interventions can occur early or identify adolescents who already have drug problems so they can be referred for treatment. Drug abuse not only interferes with a student's ability to learn, but it can also disrupt the teaching environment, affecting other students as well. (NIDA, 2007, para. 3).

ROLE OF SCHOOL NURSE

School nurses have the expertise and education to assist with a community needs assessment. School nurses may provide primary, secondary, and tertiary prevention services in substance use and abuse prevention and are knowledgeable about community-based referral resources and confidentiality. The complex issue of drug abuse among youth goes beyond simply performing routine and random drug testing in schools, which efficacy is in question.

If a district is considering a random drug testing program, then the school nurse should be an active participant in the discussion along with community members, board members, teachers, parents, physicians, and addiction professionals and recommend the science be examined before a costly program is implemented. In addition, resources to assist students when positive test results occur must be available and include primary care health providers and addiction professionals.

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This document replaces the following Position Statement:

The Role of the School Nurse Regarding Drug Testing in Schools (adopted June 2003).



National Association of School Nurses

ISSUE BRIEF

School Health Nursing Services Role in Health Care

Eating Disorders

INTRODUCTION

Eating disorders are among the leading health problems in the United States. Typically diagnosed during adolescence, initial symptoms of eating disorders “are becoming more prevalent ... in elementary and middle school years” (White, 2000). The most common eating disorders - anorexia nervosa, bulimia, and binge eating - involve issues and behaviors around body image distortions, food, and interpersonal relationships. Eating disorders are serious, complex, and sometimes fatal.

BACKGROUND

Throughout the United States, as many as 5 - 10 million adolescent girls and women and nearly 1 million boys and men are struggling with eating disorders (National Eating Disorders Association, 2001). In the past it was believed that the population at risk was affluent, young girls. More recent research reveals that risk factors for eating disorders are much broader and multifaceted (Marshall, 1998; ANRED 2002; White, 2000),

- Biologic risk factors: affective disorders, chemical deficiencies, endocrine abnormalities
- Individual risk factors: age (elementary through college age), low self-esteem, identity issues, gender
- Family risk factors: conflict avoidance, boundary issues, and dysfunctional patterns
- Cultural risk factors: emphasis on thinness, chronic dieting, and dissatisfaction with body.

The school nurse is in a prime position within the school setting to identify students with actual or potential eating disorders because of her/his regular contact and interaction with students.

RATIONALE

Studies indicate that eating disorders most commonly peak during the school age years and may be found during routine school nurse screenings or assessments (ADA, 1998; ANRED 2002; White, 2000). The school nurse office may offer a comfortable environment for students at risk for developing eating disorders to learn how to cope with destructive attitudes and behaviors. School nurses are excellent resources for staff members who have identified students at risk. The school nurse has connections with mental health-care providers and is often in a position to determine appropriate referrals/contacts within the community.

ROLE OF THE SCHOOL NURSE

The National Association of School Nurses believes that students with eating disorders have the right to receive health care that is planned, provided, supported and/or managed by the professional school nurse. School nurses are uniquely prepared to assess and to formulate a nursing diagnosis and plan of care for a student diagnosed with an eating disorder. As appropriate, the school nurse involves the family or outside referral agencies for further evaluations. Surveillance for risk factors and prevention through health education/support groups with at-risk youth provides an opportunity to identify students early. The school nurse can play a vital role in the promotion of greater therapeutic success and greater school success in the treatment of students with eating disorders.

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June 2002

INTRODUCTION

Children and adults may experience medical emergency situations because of injuries, complications of chronic health conditions, or unexpected major illnesses in schools (American Academy of Pediatrics [AAP], 2008). Providing an environment that is responsive to emergency health needs of students is essential to creating a safe school setting (Bobo, Hallenbeck, & Robinson, 2003). School districts are accountable for developing programs that to the greatest extent possible provide an effective response to urgent and emergency health problems of students, staff, and even visitors to school buildings (Schwab & Gelfman, 2005). The National Association of School Nurses (NASN) supports an established minimal standard of emergency equipment and supplies to minimize further systemic insult or injury and manage life-threatening emergency conditions. These supplies should be carefully organized and monitored by protocol and be readily available for trained school staff (AAP, 2008). Table 1 lists recommended emergency supplies and equipment for schools without a registered professional school nurse (hereinafter referred to as school nurse) present, and Table 2 lists the same for schools with a school nurse present (Bobo et al., 2003; Drezner et al., 2007). Preparation of emergency equipment and supplies in the school for an individual emergency goes hand in hand with overall emergency and disaster preparedness for the school community at large. The later topic is covered in the NASN Position Statement "Emergency Preparedness -The Role of the School Nurse".

BACKGROUND

Academic success has been repeatedly linked to a child's health (Centers for Disease Control and Prevention [CDC], 2011). Children spend a significant portion of each day in school, where up to 25% of childhood injuries occur (Olympia, Wan, & Avner, 2005; AAP, 2008). Nearly all schools provide on-site first aid to students. However, the actual emergency equipment present in schools varies widely. Schools cannot accomplish their academic mission without addressing the health and safety of the students, including emergency response. Yet the definition of emergency in the school setting, where teaching and learning are the focus, differs greatly from an emergency in the acute healthcare setting. School staff often see any health issue that interferes with academics as an emergency. There are also myriad issues affecting recommendations on how to best prepare schools to respond to potential health emergencies safely and effectively.

Many argue that prevention is the key and that having prevention programs in place at school would diminish the frequency and intensity of emergency treatment interventions needed at school. While this is true, one cannot ignore the fact that injuries can, and do, happen despite our most vigilant attempts to prevent them. Safe Kids USA (2011) reports the following:

- About 3.5 million children (ages 14 and under) get hurt each year playing sports or participating in recreational activities.
- Approximately 2 out of 5 traumatic brain injuries among children are associated with participation in sports and recreational activities.
- The most common types of sport-related injuries in children are sprains (mostly ankle), muscle strains, bone or growth plate injuries, repetitive motion injuries, and heat-related illness.

Furthermore, 25% of children seeking treatment at hospital emergency rooms have either special healthcare needs or chronic illness (AAP, 2008). An estimated 16.2% of children under age 18 have special healthcare needs (Chevarley, 2006), and 2.2 million children have two or more chronic conditions, e.g., asthma, diabetes, epilepsy. These children are at higher risk for medical emergencies while in school (AAP, 2007, 2008).

Unexpected medical emergencies, such as sudden cardiac arrest, are possible among both students and adults present in schools (CDC, 2001; Drezner et al., 2007; Lofti et al., 2008). Olympia et al., found in a 2005 survey that 68% of the school nurses had managed a life-threatening emergency requiring emergency medical services (EMS) contact in the previous year. Although school nurses' primary role is the care of students, they are often called to respond to adult staff and visitors experiencing emergency conditions such as cardiac arrest, stroke or other

unexpected illness. The burden of being prepared is increased when school nurses have to serve more than one facility. School staff may be required to deal with emergencies when the school nurse is not available or assigned to another school (Evers & Puzniak, 2005). Impacting recommendations for emergency equipment and resources for schools will be the varied skill levels of school personnel responding to the emergency health needs of students, as well as nurse licensure levels and governing nurse practice acts.

Reviewing the literature provides limited guidance for recommending the minimal essential medical equipment and resources for schools. Although increasing attention and research have been paid to injuries and medical emergencies at school (AAP 2007, 2008; American Heart Association [AHA], 2004; CDC, 2001, 2011; Lofti et al., 2008; Utah Dept. of Health, 2009), few report recommendations of emergency equipment and supplies for schools (AHA, 2004; Bobo et al., 2003; Drezner et al., 2007; Wisconsin Department of Public Education, 2009). The seminal list of recommended supplies remains the minimal standard list reported by Bobo, et al. (2003), the result of a 15 member consensus group representing a wide range of pediatric emergency agencies. One change of note since this list was reported is the inclusion of an automated external defibrillator or AED. The consensus group did not include AED on its list after considering its cost effectiveness and training and maintenance issues. However, AHA (2010, 2004) and Drezner et al., (2007) now recommend including an AED if a school meets one of the following criteria:

- There is a reasonable probability of AED use within 5 years of rescuer training and AED placement; OR
- There are children attending school or adults working at the school who are thought to be at high risk for sudden cardiac arrest (e.g., children with congenital heart disease); OR
- The EMS call-to-shock is MORE than 5 minutes AND a collapse-to-shock interval is LESS than 5 minutes can be reliably achieved by training and equipping laypersons.

An AED is never just a piece of equipment, but is an acknowledged extension of a complete AED program that includes maintenance standards and regular training in CPR and AED response. Other changes made to this list include updates in hand hygiene, blood borne pathogen standards, and minor changes to reflect current nomenclature.

RATIONALE

Students are the population of primary responsibility for a school nurse. However, schools are places of mass gatherings. On any given day, more children and adults—up to 20% of the USA population—are gathered in school settings than in any other location in the community (AHA, 2004; Graham, Shirm, Liggin, Aitken, & Dick, 2006). It is therefore not only prudent but also an obligation of the school to have the equipment necessary to minimally stabilize both the sick or injured student and adult staff member or visitor.

Acknowledging the varied skill and licensure levels of school personnel responsible for administering first line care and treatment of student emergencies, more than one list of recommendations is warranted: one list of minimal equipment and resources required in schools where a school nurse may not be present and one including additional equipment and resources for schools with a school nurse available on the premises.

Equipment is merely one aspect of ensuring that the emergency health needs of students are addressed. A well-coordinated emergency response plan, which includes a reliable campus-wide communication system and training of school personnel, is imperative to ensure well-defined, appropriate interventions are implemented appropriately and in a timely fashion (AHA, 2004; Drezner et al., 2007).

ROLE OF THE SCHOOL NURSE

Each school nurse has a responsibility to analyze and anticipate the types of equipment and services that should be available to best meet the school's needs, building on the national recommendations for schools without a school nurse present and those with a school nurse (Bobo et al., 2003). This vital information will also become part of the school-wide emergency plan.

School nurses must advocate for supplies and equipment for the health and safety of students and staff. The liability of not being adequately prepared to deal with school emergencies outweighs the cost of having supplies and trained personnel to handle emergencies in schools.

Table 1
MINIMAL ESSENTIAL EMERGENCY EQUIPMENT AND RESOURCES
FOR SCHOOLS WITHOUT A SCHOOL NURSE PRESENT

Accessible keys to locked supplies
 Accessible list of phone resources
 AED if school meets the AHA guidelines
 AED supplies stored with AED (razor, alcohol pads, dry towel, scissors, electrode pads)
 Biohazard waste bags
 Blunt scissors
 Clock with a second hand
 CPR trained staff on-site when students are on the premises
 Disposable blankets
 Emergency cards on all staff
 Emergency cards on all students
 Established relationship with local EMS personnel
 Eye protection (full peripheral glasses or goggles, face shield)
 Ice (not cold packs)
 Individual care plans/emergency plans for students with specialized needs
 First aid tapes
 Non-latex gloves
 One-way resuscitation mask
 Phone-cell or other two way communication device
 Posters with CPR/ abdominal or chest thrusts instructions
 Refrigerator or cooler
 Re-sealable plastic bags
 School-wide emergency operations/response plan
 Sharps container
 Soap and source of water/hand sanitizer for hand and wound cleansing
 Source of oral glucose (i.e., frosting gel, glucose tablets, juice box)
 Splints
 Staff names who have received basic first aid training
 Variety of bandages and dressings
 Water source/normal saline for wound/eye irrigation

From Bobo et al., 2003; Drezner et al., 2007

Table 2
ADDITIONAL MINIMAL ESSENTIAL EMERGENCY EQUIPMENT AND
RESOURCES FOR SCHOOLS WITH A SCHOOL NURSE PRESENT

- C-spine immobilizer of different sizes
- Glucose monitoring device*
**Committee acknowledges challenges with maintenance and expense of test strips. Monitoring of machine must also be in compliance with CLIA (Clinical Laboratory Improvement Amendments)*
- Medications *
 Albuterol
 Epinephrine (auto injector preferred)
- Oxygen
**All medications including oxygen should be in accordance with state laws, pharmacy, and nurse practice acts.*
- Nebulizer
- Penlight
- Self-inflating resuscitation device in two sizes (500 ml and 1 liter) with appropriate sized masks to meet needs of population being served

- Stethoscope
- Sphygmomanometer and cuffs in pediatric, adult regular and adult large sizes
- Suction equipment (minimal source, does not have to be electric, i.e., turkey baster)

From: Bobo et al., 2003

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This document replaces the following Position Statement:

Preparing for School Emergencies (adopted November 2003)

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National Association of School Nurses
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INTRODUCTION

Environmental health is a branch of public health that is concerned with all aspects of the natural and built environment. The World Health Organization (WHO) defines environmental health as those aspects of human health and disease which are determined by factors in the environment. It also refers to the theory and practice of assessing and controlling factors in the environment that can potentially affect health (WHO, 2011).

In the school setting, environmental health is affected by the complex interaction of the school's location, occupants, and school activities, which include -- but are not limited to -- building materials, insulation, carpets, art, music and science rooms, computer labs, health rooms, playground equipment, food preparation areas, waste management, cleaning products, pest management, fragrances, parking lots, bus areas, heating/cooling equipment and ventilation, gymnasiums, sports fields, and custodial and maintenance areas.

BACKGROUND

Historically, our understanding of the impact of environmental pollutants on health began in the 1960s and 1970s. In 1977 it was discovered that 20,000 tons of hazardous chemical wastes were buried beneath an elementary school in Niagara Falls, NY. Love Canal, the local dumpsite, was declared as a State of Emergency in 1978. The incident drew international attention to the threat of unregulated hazardous waste dumping in communities and began the discussion of toxin exposure and children's health (Centers for Disease Control and Prevention [CDC], 2010). According to the WHO, approximately 25% of the human diseases are a result of prolonged exposure to environmental toxins (WHO, 2011). Known health effects of toxin exposure include asthma, cancer, cardiovascular failure, developmental defects and delays, effects on vision, hearing, growth, intelligence, and learning (Institute of Medicine [IOM], 2011).

It is estimated that 55 million students spend at least six hours a day, five days a week, in the nation's 115,000 public schools (Environmental Protection Agency [EPA], 2012a). Current environmental studies have shown that at least half of these schools have poor indoor air quality (Healthy Schools Network, 2009). Additionally, there are almost 6 million students in non-public schools (National Center for Education Statistics [NCES], 2011) and 50,000 students in Bureau of Indian Education (BIE) Schools (2011). A 2007 report by the Inspector General, Department of the Interior, stated there is a need for "immediate action to protect the health and safety of students and faculty" in BIE schools. He described "severe deterioration that directly affects ... their ability to receive an education" (Devaney, 2007, pg. 1).

"Healthy school buildings contribute to student learning" (Healthy Schools Network, 2009, p. 5). The WHO recognizes that "Clean air is a basic requirement of life. The quality of air inside homes, offices, schools, day care centers, public buildings, health care facilities or other private and public buildings where people spend a large part of their life is an essential determinant of healthy life and people's well-being" (WHO, 2011, Foreword pg. xv). Poor indoor environmental quality has been linked to increased student illness (IOM, 2011). Symptoms include allergic reactions, upper and lower respiratory infections, headaches, dermatitis and fatigue (Environmental Law Institute, 2009; Selekman & Coates, 2013). Outdoor air pollution has been shown to contribute to numerous health effects, ranging from minor lung irritation to acute and long term lung impairments (Suwanwaiphatthana, 2010). Any of these symptoms can impair the ability of the student to learn.

According to the EPA, “Children are inherently more vulnerable to environmental hazards because their bodies are still developing. Substandard environmental conditions in schools, such as insufficient cleaning or inadequate ventilation, can cause serious health problems for children” (EPA, 2010, p. 1). Children experience higher exposure rates to environmental pollutants than adults because, per pound of body weight, they breathe more air and ingest more food and water than adults, increasing their exposure to potentially harmful chemicals (IOM, 2011). These chemicals may be the very products used by the school to keep the environment clean and/or pest free. Children also have more hand-to-mouth contact, which can lead to increased ingestion of toxins. Likewise, adolescence is a time of rapid cell growth during puberty, and many youth may be exposed to toxic chemicals at school and in work environments (Sattler & Davis, 2008).

Noise quality is also an important factor in environmental health. It is well recognized that the acoustical qualities in a classroom or other educational environments are a critical variable in the academic and psychosocial development of children. Inappropriate levels of reverberation and/or noise can deleteriously affect speech perception, reading/spelling ability, classroom behavior, attention, concentration, and educational achievement. In addition to compromising student function, poor classroom acoustics may also negatively affect teacher performance and increase voice problems (American Speech-Language-Hearing Association, 2005).

RATIONALE

The registered professional school nurse (hereinafter referred to as school nurse) is the health expert in the school setting. With a public health focus, the school nurse has the educational and clinical background needed to understand the issues of environmental health and advocate for a physically and emotionally healthy school community (American Nurses Association [ANA] and National Association of School Nurses [NASN] (2011). The school nurse can assess the school environment for risk factors, advocate for the school community to address environmental pollution issues, and educate the community to the impacts of environmental issues and exposures. As a first responder in the school setting, the school nurse is able to identify trends and abnormal illnesses that may be related to environmental toxin exposure. The school nurse has the credibility to provide scientifically sound information to school and community leaders about environmental issues and toxin exposures (Agency for Toxic Substances & Disease Registry [ATSDR], 2012).

The Occupational Health and Safety Administration (OSHA) has been given the responsibility to ensure that employers provide a safe and healthy working environment, including schools. It accomplishes this through many regulations that relate to occupational exposure to environmental toxins (OSHA, 2012a). The school nurse can assist in implementing safety standards and in making the standards understandable and applicable in the school setting.

“Environmental preferability, sustainability, ‘green’, reducing your environmental footprint . . . these terms have become part of our everyday lexicon as schools, businesses, households, and the public sector have increasingly focused on strategies and tactics designed to reduce their negative impacts on the environment and human health” (Balek, 2012, pg. 16). Many activities to control school environmental exposures, including cleaning products used, will be the responsibility of the districts’ building or maintenance departments. The school nurse can serve on committees or as a consultant regarding activities that impact safe environmental practices, such as products to be used in the school setting.

THE ROLE OF THE SCHOOL NURSE

The school nurse can promote environmental health by the following:

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1. Participate in and /or lead school committees for improving and maintaining good indoor air quality (Resource: EPA's *Tools for Schools IAQ Management* program, 2009).
2. Participate in the school and/or district committees for workplace safety and participate in the development of policies and practices that reduce exposure to environmental hazards.
3. Conduct or review annual environmental risk assessment (Resource: EPA's *Risk Screening Environmental Indicators*, 2011a). (Check the state's education code to see if it requires schools to be inspected regularly to insure minimal health and safety regarding the roof, interior and exterior of the building structure, plumbing, heating/cooling, ventilation, and wiring (Environmental Law Institute, 2009). Follow the guidelines for animals in the school setting (Resource: CDC, 2011).
4. Promote use of an Integrated Pest Management system for pest control (Resource: EPA's *Integrated Pest Management Principles*, 2012b).
5. Advocate for building maintenance projects to be completed outside of school operating hours when possible, in order to reduce or limit staff and student exposure to possible fumes or chemicals (for example: painting and caulk that contains latex).
6. Educate staff and students on current environmental health concerns; participate in community programs for environmental safety.
7. Follow hazardous waste management policies at the local school and district level (Resource: EPA's *Managing Hazardous Waste in Your Community*, 2011b).
8. Follow guidelines concerning bloodborne pathogens in the school setting (Resource: OSHA's *Bloodborne Pathogens and Needlestick Prevention*, 2012b).
9. Support and enforce smoke-free school environments.
10. Assist with emergency response plan development for environmental toxin/hazardous chemical exposure accidents.
11. Understand and advocate for implementation of policies that encourage use of "green" cleaning products to further reduce toxin exposure in the school setting.
12. Understand the connection between daily noise exposure and learning and advocate for school buildings to meet current acoustical standards (Acoustical Society of America, 2010).
13. Educate students and staff on causes of noise-induced hearing loss and the importance of hearing protection at home and school, and advocate for continued routine hearing screenings with appropriate referral and follow up.
14. Document health events that may be caused by environmental exposures and report to administration.

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This document replaces the following Issue Brief:
Environmental Concerns in the School Setting (Adopted: 2004)

This document replaces the following Position Statements:
Environmental Impact Concerns in the School Setting (Adopted: 1991; Revised: 1998, 2005)
Indoor Air Quality (Adopted: June 2000; Revised: June 2005)
Noise Induced Hearing Loss (Adopted: June 2003)

For more information refer to: NASN Environment Health web page @
<http://www.nasn.org/ToolsResources/EnvironmentalHealth> and to NASN's Service Animals in Schools Issue Brief

INTRODUCTION

The National Association of School Nurses (NASN) endorses a school nurse obligation to advocate for meeting students' health care needs, thereby improving student learning and educational achievement.

BACKGROUND

Since the inception of school nursing in the United States, school nurses have advocated for the improved health of students. In 1903, the first experimental program in New York to determine if school nurses could decrease absenteeism was successful in documenting that school nurses made a difference. As a result, school districts across the country began to hire nurses to work in schools.

RATIONALE

School nurses are uniquely qualified to assume a grassroots advocacy role and stimulate change in the health care system on a local and state level for improved health and learning of students. School nurses are one of the only health professionals who can bridge the health care system and the education system. They are experts in surveillance, child health, acute care, public health, and the health care system. They see the synergy that can occur when the systems complement each other to support children and families. School nurses witness firsthand where systems fall short and children fall through the cracks. They have a professional perspective on how well-meaning changes in education or health provisions can produce unintended consequences. Most school nurses serve in the community in which they live. This connection to the community fosters a sensitivity to local inequities affecting child health and education (Robert Wood Johnson Foundation [RWJF], 2010).

At the national level, NASN maintains a director of government affairs to manage priorities and advocate in a non-partisan manner on behalf of the practice of school nursing. With the expected increase in the number of children with complex medical, genetic, and psychiatric health conditions that require more nursing oversight, school nursing provides the expertise and coordination to assure that children receive the care they need. School nurses are at the forefront of promoting and developing innovative school programs.

Elected officials and school administrators at all levels need to be informed of the increasing numbers of students entering schools with chronic health conditions that require management during the school day. The school nurse has access to research to propose evidence-based solutions to problems identified in school nursing practice. Through the school nurse's experience as a case manager for students with complex health needs and their position in the school, school nurses can provide real life examples to elected officials and discuss the impact of proposed legislation on students and their education.

THE ROLE OF THE SCHOOL NURSE

According to the American Nurses Association's (ANA) *Code of Ethics for Nurses* (ANA, 2001), nurses are responsible for "articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy". This responsibility is incorporated in the *Scope and Standards of Practice for*

Professional School Nurses (NASN & ANA, 2005) as a standard to advocate for the client. To fulfill this role, school nurses need to stay abreast of health policy issues especially as they affect schools and students and be visible and heard as the expert in school nursing when child health and education issues are being addressed. Individual school nurses do this by cultivating a relationship with legislators and decision makers at the community, state and national level. NASN facilitates this role by having a national presence in the health and education policy arena (Embrey, 2010). Affiliates facilitate advocacy efforts on a state and local level. Being part of “the conversation” is essential for explaining the seamless provision of comprehensive health services to children and youth.

Today, school nurses advocate in local, state, and national arenas by staying informed on current issues, writing letters and e-mails, and speaking to decision makers. Student health issues which affect key policies and regulatory areas impact the standards of practice for school nurses. Specific areas of advocacy include:

Advocacy with Decision Makers

- Local public health policies and regulations
- Local school/medical advisory board regulations
- State nurse practice acts, rules, regulations, and declaratory rulings
- State and federal laws regarding minors’ consent to treatment, confidentiality, professional liability, and other school health services issues

Advocacy with Health and Education Associations

- National association policy statements, e.g. American Academy of Pediatrics Policy Statement, “Role of the School Nurse in Providing School Health Services” (AAP, 2008) and ANA’s 2007 statement , “Assuring Safe, High Quality Health Care in Pre-K Through 12 Educational Settings”
- National Education Association (NEA) and American Federation of Teachers (AFT)

Advocacy with Specific Legislation

- Elementary and Secondary Education Act (ESEA)
- State and Federal Child Health Insurance Program (CHIP)
- Individuals with Disabilities Education Act (IDEA)
- Americans with Disabilities Act (ADA)
- Section 504, Rehabilitation Act of 1973
- Family Educational Rights and Privacy Act (FERPA)
- Health Insurance Portability and Accountability Act (HIPAA)

Through continued advocacy at the local, state, and national levels, decision makers will have a greater understanding of the current role of the school nurse, which is linked to public health and wellness. Additionally, the school nurse “client system” now includes the child, the family, school personnel, and the community. Today, school nurses recognize their most valuable impact occurs in roles that support students’ educational success. In addition, school nurses affect health dollars and health care systems by assisting students and families to access appropriate health care services. A strong emphasis on government relations and advocacy will advance the school nurse impact on health and learning.

School nurses are encouraged to acquire the skills needed to influence public policy and use their individual and collective voice to advocate for student health. The promotion and protection of the health of children will advance educational outcomes and will help to ensure safe and healthy school communities.

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This document replaces the following Position Statement:

Government Relations: Public Policy, Legislative, and Regulatory Advocacy (Adopted: 1998; Revised: 2003)



National Association of School Nurses

ISSUE BRIEF

School Health Nursing Service Role in Health Care

Health Promotion and Disease Prevention

INTRODUCTION

A person must give attention to the body, mind, and spirit to be healthy. In order to manage health and illness along this continuum, everyone requires skills that promote health and prevent disease. By helping promote these skills among the school staff, students, and the broader school community, the school nurse has an opportunity to contribute to the nation's goals of health promotion, disease prevention, and decreasing disability.

BACKGROUND

Epidemiological studies provide evidence of the role modifiable risk factors play in many chronic diseases. While there is less disease in the United States due to infectious agents than there once was, there is more disease related to industrial, technological, and lifestyle changes (U.S. Department of Health and Human Services [USDHHS], 2000). The Surgeon General also estimates that perhaps 50 percent of premature death and disability is related to unhealthy behaviors (e.g., lack of physical exercise, injury and violence, lack of a healthy diet, substance abuse, lack of responsible sexual behavior). The common denominator in the leading causes of morbidity and mortality in the United States is unhealthy lifestyle behaviors, behaviors that can be modified (USDHHS, 2000; USDHHS, 2003; Bloom, Cohen, Vickerie, & Wondimu, 2003).

Unfortunately, health trends are unfavorable. Diabetes, cancer, and other chronic diseases continue to burden our health care system. Violence and abusive behaviors continue to ravage homes and communities. Mental disorders continue to be undiagnosed and therefore untreated. Obesity is up 50 percent over the last two decades. Tobacco smoking has risen among adolescents in the last ten years. Forty percent of adults have no leisure physical activity. And disproportionate rates of HIV/AIDS exist among women and communities of color (USDHHS, 2000; Bloom et al., 2003; USDHHS, 2003). Globally, the leading causes of morbidity, such as heart disease, major depression, traffic accidents, stroke, and chronic lung disease, also appear to be linked to largely preventable causes.

These chronic diseases carry direct and indirect costs. Currently, in the United States direct health care consumes around 14 percent of the gross national product. Indirect costs include losses in work productivity and absenteeism (both for school staff and students). By modifying health behaviors, many of these health problems can be prevented. The savings in direct and indirect health care costs is yet to be realized.

The school environment adds its own unique set of health risks, especially those that take a toll on the mind and spirit of staff. These risks come from a variety of sources. From within the school staff, pressures are created when conflicts arise between the demands created by standardized educational benchmarks and the personal desire to be creative and effective teachers. Staff also struggle with time constraints, trying to stay current in their fields while balancing the demands of day-to-day work and family. Within the classroom, issues of class size, workload, limited resources, student culture, and safety confound pressures felt by staff and student alike. Pressures from outside the classroom include the nurse, teacher, and counselor shortage; parents; and the public. The school environment clearly plays a role in the health risks of staff and students.

Health and wellness include several dimensions: physical, emotional, spiritual, intellectual, occupational, and social. Health can be viewed as a continuum and dynamic state that is influenced by the perception of the individual. Along this continuum, a person moves between health and illness. Health is more than the absence of disease. People can live with a medical diagnosis and still consider themselves healthy because of the way they care for their mind, spirit, and body (Edelman & Mandle, 1997; Pender, 1996). Illness is a person's response to a disease or dysfunction. Disease is the medical diagnosis given for a defined set of signs and symptoms.

Maintaining a healthy state can occur with little effort for some people, while others have to be actively involved to achieve this state of physical, mental, and social well-being. Achieving wellness, however, always involves being actively engaged in choosing health seeking behaviors. Health promotion strategies target behavior change that reduces risk for disease and promotes movement up the health continuum. Disease prevention strategies target ways to avoid illness or disease. Choosing effective health promotion (e.g., enhancing current activity and/or dietary practices, incorporating meditation or relaxation techniques to enhance life balance) or disease prevention (e.g., regular medical exams, obtaining recommended immunizations) strategies depends on the degree of risk for an individual or group. Health risk can be determined through focused risk appraisal and/or disease screening. Health risks can also be estimated using evidence-based recommendations (U.S. Preventive Services Task Force, 1996; U.S. Preventive Services Task Force, 2002; Edelman & Mandle, 1997).

The school nurse's role in promoting health and preventing disease at school is clearly supported by a *Coordinated School Health Program* approach, *The Scope and Standards of Professional School Nursing Practice*, and *Healthy People 2010*. A *Coordinated School Health Program* devotes one of its eight components to school-site health promotion for staff. In the other seven components of this model, promoting health and preventing disease for students and the broader school community are also clearly evident (e.g., physical education, school health services, school nutrition services, school counseling, healthy school environment, family and community involvement) (Marx & Wooley, 1998).

Healthy People 2010 (USDHHS, 2000) globally addresses goals and strategies to prevent premature death, disability and disease in this country. The leading health indicators -- lack of physical activity, overweight and obesity, tobacco use, substance abuse, lack of responsible sexual behavior, mental health, injury and violence, poor environmental quality, lack of adequate immunizations, and inability to access to care -- highlight major contributors to morbidity and mortality in the United States, and they provide targets for how behavior change can lead to positive health outcomes.

Many schools are taking an active role in promoting health and preventing disease. Regardless of the specific model schoolwide program model, the following components appear to be universal: needs assessment, developing partnerships within and outside the school to promote a sense of community ownership, incentives to provide motivation, creative messaging to deliver an impressionable health message, and follow-up to provide reinforcement. The school nurse can review these model programs and incorporate those components that best match the health needs and culture of their school (Marx & Wooley, 1998).

RATIONALE

It is the position of the National Association of School Nurses that the school nurse has a role in promoting health and preventing disease in the school community he/she serves. In light of the growing prevalence of behavior-linked disease, the school nurse possesses the knowledge and skills to role model, deliver educational messages, and plan programs that focus on health promotion and disease prevention for the school community.

Supporting a healthy culture in the school environment is essential for promoting individual and organizational health and wellness. Having this supportive culture, which can be fostered by the school nurse, is critical to helping students, staff, the school community, and the school nurse who are trying to make lifestyle changes to improve health.

ROLE OF THE SCHOOL NURSE

Promoting health and preventing disease within the school community is within the scope of school nursing practice. *The Scope and Standards of Professional School Nursing Practice* (ANA & NASN, 2001) assists the school nurse in identifying health needs and implementing services to promote healthy behaviors and prevent disease.

The school nurse's position in the school community affords the opportunity to serve as a source of reputable health-related information (e.g., community resources, written materials, health classes, one-on-one counseling). The school nurses possess the knowledge and skills to assist in monitoring the progress of health behavior changes by those in the school community (e.g., blood pressure measurements, height and weight measurements). Through the school nurse's health and wellness behaviors (e.g., not smoking, daily exercise, stress management strategies), she/he role models behaviors that can be copied by those in the broader school community. School nurses possess the knowledge and skills to identify and/or develop, secure, and implement health and wellness programs for school staff, students, and the broader community.

The school nurse role first involves assessment of the health risks of the school community she/he serves. Health risks unique to the school community can be determined by conducting risk assessments and disease screenings. School-based data can also be compared with national norms for age, ethnic group and region to determine leading areas of health risk, and therefore determine the focus for health promotion and disease prevention activities for the school (Allegante, 1998; Edelman & Mandle, 1997; Galemor, 2000).

After summarizing the health risk assessment data (for students, school staff, and/or the broader school community), the school nurse can then determine which health promotion and disease prevention strategies are most appropriate. Strategies should incorporate the various dimensions of health and wellness, target risk factor reduction, and can be designed for the individual or school. Through the development of a focused health promotion and/or disease prevention plan, steps can be taken to reduce the leading causes of morbidity and mortality for the school. Examples of health promotion/disease prevention strategies include the case finding that is accomplished during the assessment phase (e.g., risk appraisal or disease screening); health education and counseling; promoting immunizations; meditation; and eastern therapies that promote relaxation techniques; and low impact exercise. Developing schoolwide policy is also a powerful intervention strategy that can target the broad issues and greatly impact the school culture (e.g., issues of worksite safety, staff stress and employee assistance) (Allegante, 1998; Edelman & Mandle, 1997; Galemor, 2000).

Guidance for specific steps to take in developing a school-site health promotion program is available in the literature (Marx & Wooley, 1998). Overall, the problem solving process outlined by the nursing process is key.

Promoting health in the school setting is foundational to academic success (Satcher & Bradford, 2003; California State Legislature, 2002). The school nurse serves students, school staff, and the surrounding community, each interconnected with the other. A focus on health promotion and disease prevention at school will have a ripple effect on the health and wellness of the entire school community served by the school nurse.

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November 2004



National Association of School Nurses

ISSUE BRIEF

School Nurse Role in Education

SCHOOL HEALTH RECORDS

INTRODUCTION

One of the most challenging responsibilities of school nurses is managing the many types of student health records, both paper and electronic. They include documents such as immunization records, screening records, progress notes, physician orders, physical examination records, medication and treatment logs, individualized health care plans, emergency health care plans, third party medical records, consent forms, Medicaid and other insurance billing forms, and flow charts.

School health records provide the mechanism for a school nurse to communicate information to students, families, the school multidisciplinary team, emergency personnel, other health care providers, and school nurse substitutes. Data from school health records can be used to show evidence of student health problems that should be addressed. Data can also be used for evaluation of school health programs, quality assurance, and evaluation of program outcomes. School health records are transferred to new school sites when a student progresses to other buildings within a district or moves to another district.

It is important for school districts to have policies and procedures regarding the types, maintenance, protection, access, retention, destruction, and confidentiality of student health records. State laws and regulations may dictate these policies and procedures (Harrigan, 2002).

As society and the health care system are moving from paper to electronic technology, so too is the school health office. Technology currently in use to receive and transmit student health information includes:

- Answering machines
- Cellular and cordless telephones
- E-mail via computer
- Facsimile machine (fax)
- Personal digital assistant (PDA)
- Voice mail

BACKGROUND

The following areas are considered when examining a school health records system:

- The foundation and rationale for any school health records system should be based on who needs the information, what information they need for the benefit of the student, and who has the expertise to interpret the records (National Association of State School Nurse Consultants, 2000; Schwab & Gelfman, 2001).
- School health records are maintained for purposes of communication, legal evidence, research, education, quality assurance monitoring, statistics, accrediting/licensing, and reimbursement (Schwab, Panettieri, & Bergren, 1998).
- In keeping with medical record requirements, school health records are cumulative and chronological, and errors are not changed, rather recorded on the appropriate date (Schwab & Gelfman, 2001).
- Management of student health records includes their generation, maintenance, protection, disclosure, and destruction. Privacy, confidentiality, and consent are related to record management. (NASN, 2002).

- Paper records are generally kept in locked files. Some school staff will need immediate access to some health information, such as that in emergency care plans, 504 plans, IEPs, and written instructions for care providers (Schwab & Gelfman, 2001).
- Laws governing school health records include the Federal Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) as well as individual state laws (Bergren, 2001c).
- Computer databases that provide comprehensive student health records and health office logs are available. These are enhanced by nurses using personal computers linked to a network of computers in a building or district. Some school nurses serving multiple buildings use notebook computers to carry from school to school and connect to the network while in each building (Schwab & Gelfman, 2001).
- Fax machines are widely used for transmitting health information. In schools, fax machines streamline accessing such records as immunizations, parental permissions, doctor's orders, clinic records, and pharmacy communications regarding medications (Bergren, 2001b).
- PDAs augment computers by sharing information with them. Some school nurses find PDAs useful for digital data collection and retrieval. Student health data is collected during screenings or accessed during emergencies on the school campus. Information is uploaded onto the school nurse's computer at a later time (Suszka-Hildebrandt, 2001).
- E-mail has become a standard method of communicating in the school setting among staff in and outside of the school district. E-mail is self-documenting and can be retained in a paper or electronic health record at the time of the exchange, eliminating the need for additional notation. The original message is preserved into a file by downloading (Bergren, 2001a).

RATIONALE

Health information in either paper or electronic form must be confidential, secure, accessible only by authorized staff, and protected from loss or destruction (Bergren, 2001b). Information transmitted via the newer technologies is different from paper records in that it can be fairly easily misdirected, intercepted, rerouted, and read by recipients for whom it is not intended (Bergren, 2001a). Because of this, new methods of security must be undertaken.

ROLE OF THE SCHOOL NURSE

School nurses need to address the many issues surrounding student health records in the school health office. Ensuring the security and privacy of both electronic and paper records is of utmost importance. In addition, school nurses must know the relevant federal and state laws, regulations, and guidelines about school health record maintenance, protection, disclosure, and destruction. In addressing these issues, school nurses should evaluate school district policies and procedures, initiate changes if indicated, and educate staff, students, and parents (NASN, 2002).

Electronic records and their transmission pose potential problems that school nurses must address. Special provisions must be established to protect electronic health records and student privacy in the school district. The specific method of storing student health data determines the particular opportunities for abuse of its integrity, so school nurses should be involved on the school district technology team to give input on the need for privacy. Additionally, school nurses should be able to describe the security measures taken by the school district to protect student confidentiality (Schwab & Gelfman, 2001).

Computers have streamlined record keeping for many school nurses. Along with the convenience comes the need to protect both on-screen and stored information. The use of secure passwords, programs to thwart hackers, and screen savers, as well as several areas of access for the student health data base and a policy of never leaving the computer unattended when student health data is accessible or viewable, is necessary for security. Computer software should have over-write protection and multi-level access if multiple health office employees will be entering data (Schwab & Gelfman, 2001).

Informed consent should be obtained before using e-mail for transmissions from the health office. Consent forms should describe the school district security and the expected response time, and explain that transmissions will be placed in the student's health file. The school nurse should assist the school district in establishing a policy for the type of information that may be sent via e-mail. Messages with identifiable health information should be encrypted. Additional security measures regarding e-mail include precautions to prevent misdirected e-mail; password-protected screen savers; never forwarding messages without permission of parent, health provider, or student; and prohibiting sharing of health office

e-mail accounts or passwords with anyone. A confidentiality statement should be written on all e-mail messages involving students (Bergren, 2001a).

When faxing, school nurses should include a cover page that states the confidentiality and limited use of student health information. To protect student confidentiality when faxing documents, the school nurse should fax only when mail will not suffice, transmit only requested information, keep faxes short, and obtain proper authorization. The fax machine should be located in a secure area of the school where it can be monitored by authorized staff. School nurses need to know what their individual state laws specify regarding whether a fax document can be used instead of the original signed paper document for doctors orders and prescriptions (Bergren, 2001b).

School nurses utilizing technology in the health office need to emphasize to their school administrators the importance of keeping student health information secure and private. The school technology team should provide assistance in explaining what is needed and how it can be implemented. Funding for security measures might be obtained through the school parent organization or a community service organization.

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National Association of School Nurses

ISSUE BRIEF

Individuals with Disabilities Education Act (IDEA):

Management of Children in the Least Restrictive Environment

INTRODUCTION

The Individuals with Disabilities Education Act (IDEA) grants to eligible children with disabilities the legal right to receive a free appropriate public education in the least restrictive setting. Access to education for many children is only achieved through the provision of necessary health services (e.g., administration of intravenous medications, catheterization, tracheostomy care, and gastrostomy tube feedings). The safety implications attached to these services for children support the leadership role of the school nurse in advocating for the health and educational needs of students. The National Association of School Nurses (NASN) believes that such children have the right to receive the specialized health services required to assure their inclusion and safety in the school environment, and that further, these special health services should be provided or supervised by a Registered Professional Nurse (serving as and referred to hereinafter as school nurse).

BACKGROUND

The Education for All Handicapped Children Act (EHA) was passed as law in 1975. It established national standards for the free appropriate public education of children with disability-related learning problems in the least restrictive environment. In 1990, the EHA was renamed the Individuals with Disabilities Education Act and since that time has been referred to as IDEA. Congress made amendments to IDEA in 1997 directing educational interventions for children 3 through 21 years of age who have qualifying disabilities that impede their ability to learn. Eligible students are entitled to support services at school. These are known as “related” services. The federal regulations provide definitions for the eligibility criteria and specific related services. The definitions should be considered “educational definitions”. In health care, these conditions and services may be defined differently (Schwab, Gelfman, & Cohn, 2001b, p. 387).

The 1997 IDEA amendments included a definition of IEP team members that did not include specification about the participation of a school nurse. The Congressional Record did however, in the preface to IDEA 1997, record that there are situations that merit a licensed registered nurse being on the IEP team (Committee on Labor and Human Resources, U.S. Senate, 1997, in Schwab, Gelfman, & Cohn, 2001.) However, in many jurisdictions, it remains that school nurses are not included in the multidisciplinary team that develops and implements a student’s IEP or IFSP. In these areas, specialized health services either are not included or are improperly and dangerously, performed by individuals who lack requisite training and supervision.

In 1999, United States Supreme Court ruling in *Cedar Rapids Community School District v. Garret F.* (hereinafter known as “Garret F.”) held that IDEA requires school districts to provide school nursing services when such supportive services are necessary in order for students to access and benefit from their educational program.

Garret F. held that IDEA requires a school district to be financially responsible for the provision of nursing services that students require in order to access and benefit from their educational program. The Court based its ruling on IDEA’s definition of “related services” and on the United States Supreme Court decision *Irving Independent School District v. Tatro* (hereinafter known as “Tatro”) (1984). Garret F. involved a student who required continuous nursing services in school, including urinary bladder catheterization, tracheostomy tube suctioning, nutrition and fluids on a regular schedule, positioning, monitoring of ventilator settings, artificial ventilations by ambu bag when the ventilator malfunctioned, assessment of respiratory status for respiratory distress or autonomic hyperreflexia, blood pressure monitoring, and bowel disimpaction.

NASN played an active role in Garret F. and signed on to amicus curiae (Friend of the Court) brief. This brief argued that the Supreme Court should affirm the lower Court's decisions related to the responsibility of school districts to provide the types of nursing services required by Garret F.

In 2004, IDEA 1997 was reformed again and renamed by Congress as the Individuals with Disabilities Education Improvement Act, which continues to require school districts to educate children in the least restrictive environment with emphasis on participation in the general education curriculum and a strong preference for regular classroom placement. Inclusion in the regular education setting must consider the preference used in determining the educational placement of children with any disability. Appropriate educational placement in an inclusive setting helps to break down the attitudinal and physical barriers that prevent individuals with disabilities from participating fully in society and affords an opportunity for all students to benefit from interaction and active participation with peers of chronological age, and to learn age-appropriate behavior.

Children with health conditions may become eligible for special education services if the child's disability has an impact on his or her educational performance. The school multidisciplinary team determines eligibility and necessary services, with the school nurse serving as a crucial member of the team. Because children with chronic and special health care needs have unique health considerations, individualized nursing assessment, planning, and intervention are critical to identifying appropriate placement and service decisions. The team determines the health services necessary to enable children with disabilities to attend school and to participate fully and safely in educational activities and programs. The team develops an appropriate educational program, known as an Individualized Education Program (IEP) for children 5–21 years or an Individualized Family Service Plan (IFSP) for eligible children ages 3-5 years.

RATIONALE

Managing the health and safety needs of children with profound health conditions is difficult. The interaction with the educational system is often complex because many people are involved in the process and multifaceted regulations must be addressed. State licensing laws for health care professionals identify and define professionals slightly differently from state to state.

State educational certification regulations or other mandates regarding qualifications of school nurses may also add to differences in interpretation of "qualified school nurse or other qualified person" (Schwab, Gelfman, & Cohn, 2001b, p. 393). State Nurse Practice Acts (NPA) continue to need to be reviewed to ascertain what is allowed in a particular state.

No federal law or regulation dictates who must perform certain health care procedures (Rapport & Lasseter, 1998). States' Nurse Practice Acts and other laws set forth these requirements. Delegation of nursing care to unlicensed assistive personnel may be appropriate in situations when proper assessment, training, and continued supervision can occur. Sometimes school nurses are asked to provide or delegate services that may not be delegated under that state's Nurse Practice Act. The parent or school personnel may never assume responsibility for delegating procedures requiring skilled nursing care. These actions would be considered practicing nursing or medicine without a license and could be subject to disciplinary action (Hootman & Hula, 2001).

The school nurse is professionally prepared in both issues of health and the educational process and can serve as a natural interpreter to the student, family, and health and education systems relative to students' special health needs during the school day. While estimates of the actual number of children eligible for "related services" are varied, trends in health, chronic disease, and disability for children support the need for related services. These trends include (1) increases in the number of children in schools with life-threatening allergies, (2) increases in the incidence, prevalence, and severity of asthma, (3) management of HIV as a chronic disease, (4) long-term survival of students with complex medical problems due to advances in medical technology, (5) continued increases in the number of children who are medically-fragile and technology dependent in regular classrooms, and (6) increased parental knowledge about the rights of children to education and "related services" in the least restricted environment.

The impact of Garret F. on school districts and on school nursing is significant. It is important for school districts to be aware of the increasing number of students enrolling in schools with complex medical and nursing needs. The school nurse plays a vital role in developing this awareness by explaining the implications of Garret F., IDEA 1997, and IDEA 2004 on administrative decisions about policy, staffing, collaborative decision-making, and clinical nursing practice in the

schools. This landmark decision solidifies and reaffirms the central role that school nurses play in the delivery of related school health services under the IDEA and the obligation of school districts to pay for such services.

Regardless of the actual number of students with disabilities who may require the supportive services of a nurse, school districts need to be cognizant of necessary and reasonable services and ever mindful of the inclusion and safety requirements for these students. These may include any level of service on a continuum, from direct or indirect nursing services one hour per week, a nurse on-site in the building at all times, or one-on-one nursing care throughout an entire school day. Regardless of the level of the service required, nursing services must be provided as determined in the student's IEP. It is critical therefore, for school nurses to be part of IEP teams for students whose health conditions have an actual or potential impact on their learning and for school districts to ensure that school nurses are integral members of their schools' early identification and special education teams.

Each student with a complex medical condition or a need for modification of the school environment due to a health condition should have an Individualized Health Care Plan that reflects the health needs of the student and directs how those health needs are to be managed during the school day. The school nurse should be responsible for the writing of the IHP in collaboration with the student, family, and health care providers (NASN, 1998).

ROLE OF THE SCHOOL NURSE

The school nurse plays a vital role in applying IDEA and Garret F. and in explaining its implications on administrative decisions about policy, staffing, collaborative decision-making, and clinical nursing practice in the schools. The cost of providing intensive nursing services can no longer be used as a basis for excluding students. School nurses and school nurse administrators must assist school districts in determining and identifying necessary and reasonable levels of care and are in a position to identify potential sources of payment for nursing services, such as Medicaid funds.

Because health insurance companies often have lifetime limits on coverage, some states now require school districts to disclose to families the potential impact of using their own insurance to pay for in-school services. The implication is that when parents use their own insurance benefits to cover school-based nursing services, they may be limiting their child's future available insurance coverage. School nurses can guide districts in understanding their obligation to pay for in-school nursing services when the school nurse has determined the appropriate level of care needed and included it in the student's IEP. This same guidance can be given when discussing these issues with families.

The school nurse is a team member who participates in the identification and evaluation of students who may be eligible for services under IDEA. Through shared responsibility with other team members, the school nurse assists in the planning and implementation of Individual Education Plans or Individual Family Service Plans, as needed. The school nurse ensures the safe delivery of necessary health services to eligible children with disabilities through participation on the multidisciplinary educational team and direct care with the student. As a member of this multidisciplinary education team, the school nurse assists in identifying children who may need special educational or health-related services. These include the following actions:

- assesses the identified child's functional and physical health status, in collaboration with the child, parent(s)/guardian(s), and health care providers;
- develops individualized health and emergency care plans;
- assists the team in developing an Individual Educational Plan (IEP) that provides for the required health needs of the child, which enables the student to participate in his/her educational program;
- assists the parent(s) and child to identify and utilize community resources;
- assists the parent(s) and teachers to identify and remove health-related barriers to learning;
- provides in-service training for teachers and staff regarding the individual health needs of the child;
- provides and/or supervises unlicensed assistive personnel to provide specialized health care services in the school setting;
- evaluates the effectiveness of the health-related components of the IEP with the child, parent(s), and other team members, and makes revisions to the plan as needed;
- participates in the identification and evaluation of students who may be eligible for services under IDEA, and through shared responsibility with other team members, assists in the planning and implementation of Individual Education Plans or Individual Family Service Plans as needed;

- develops student goals and objectives and nursing protocols to meet student-specific health needs during a school day, monitors student progress, and initiates an IEP reassessment when indicated; and
- serves as the team liaison to the medical community.

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Impact of Cedar Rapids Community School District vs. Garret F. on School Nursing Services

Adopted: 2001

Inclusion

Adopted: 1995; Revised: 2001

School Nurses and the Individuals with Disabilities Act (IDEA)

Adopted: 1996; Revised: 2002; **Revised: July 2006**



National Association of School Nurses

ISSUE BRIEF

School Nurse Role in Education

SCHOOL MEAL PROGRAMS

INTRODUCTION

Federal child nutrition programs provide funds for school districts to offer meals and snacks for eligible students while they are in school, before and after school, and during the summer. These are entitlement programs that enable every eligible student to receive the benefits of good nutrition. Eligibility is determined based on a student's household income (USDA, 2002a). Training and technical assistance for school food service professionals and nutrition education for students is available through the Team Nutrition Program (USDA, 2002).

Federal child nutrition programs have several benefits. They serve to help meet students' nutritional needs and lower their risk for chronic diet-related diseases. They provide students an opportunity to practice healthy eating behaviors taught in the classroom. Proper nutrition and lack of hunger improve students' concentration and ability to learn at optimal levels (National Education Association, 2003; National Dairy Council, 2003).

Despite the benefits, school meals programs often fail to meet their full potential. An increasing number of food options are competing with the program. Many of these competing foods are of low nutritional value. They include snacks and beverages found in school vending machines, school stores, school snack bars, and cafeteria a la carte foods (House Appropriations Report, 2001; National Dairy Council, 2003). Easy access to non-nutritious food and beverages in lunchrooms and in school vending machines may interfere with the selection of healthier beverage and food choices, such as milk, water, juice, fruits, vegetables, and whole grains (National Association of School Nurses, 2002).

BACKGROUND

National School Lunch Program

The National School Lunch Program (NSLP) had its inception in 1946 with creation of the National School Lunch Act. However, funding for meals had been provided to schools for many years before that. In 1946, 7.1 million students participated in the program. In fiscal year 2001, the number was 25.4 million. The NSLP is available to public and non-profit private schools and residential child care institutions. It is administered nationally by the Food and Nutrition Service (FNS); state education agencies usually administer the program at the state level. (For a list of all state agencies, check www.fns.usda.gov.)

School districts participating in the program receive cash subsidies and donated commodities from the United States Department of Agriculture (USDA) for each meal they serve. Lunches must meet Federal requirements. For instance, eligible student lunches must be offered free or at reduced price. Free meals are available to students from families with incomes at or below 130 percent of the poverty level. Students whose families have incomes between 130 and 185 percent of the poverty level are eligible for reduced-price meals costing no more than 40 cents. Cash reimbursement rates for school districts are reset yearly in July for reduced-price lunches. Reimbursement is also given for snacks for students through age 18 in after-school educational or enrichment programs (USDA, 2002a).

Local school food managers make decisions about which specific foods to serve and how these foods are prepared. However, Dietary Guidelines for Americans must be met. These recommend no more than 30 percent of an individual's calories come from fat, and no more than 10 percent from saturated fat. Regulations also establish that lunches provide one-third of the Recommended Dietary Allowances (RDA) of protein, Vitamin A, Vitamin C, iron, calcium and calories. A study of ten elementary schools in Michigan comparing school lunches with sack lunches brought from home found school lunches were more nutritious, lower in fat, and offered more variety of healthy foods (Rainville, 2003).

Nutrition assistance for non-United States citizens was clarified in 1999. At that time the Immigration and Naturalization Service announced immigrants to the United States would not be deported, denied entry to the country, or denied permanent status because they receive free and reduced-price school lunches or other nutrition assistance from FNS (USDA, 2002, September).

School Breakfast Program

The School Breakfast Program (SBP) began as a pilot project in 1966 and was made permanent in 1975. It has grown from 1.8 million students participating in 1975 to an average of 7.8 million in fiscal year 2001. It operates in the same manner as the NSLP. Breakfasts must provide one-fourth of the RDA for protein, calcium, iron, Vitamin A, Vitamin C and calories. Schools may charge no more than 30 cents for a reduced-price breakfast and are reimbursed at a rate set each July. Schools may qualify for "severe need" reimbursements, which are about 23 cents higher, if a specific percentage of students are served free or at a reduced price. (USDA, 2002b).

Summer Food Service Program for Children

The Summer Food Service Program for Children was created in 1968 by Congress. It is designed to provide funds for eligible sponsoring organizations to serve one or two nutritious meals a day to students from low-income homes when school is not in session. (National Education Association, 2003). About 13 percent of students who receive free and reduced-price school lunch participate in the Summer Food Service Program. In 2001 more than 2 million students participated at over 31,000 sites operated by 3,600 sponsoring organizations nationwide. A site is geographically eligible if it is located in an area in which 50 percent of the children qualify for a free or reduced-price meal. It is enrollment eligible if 50 percent of the children enrolled can be documented to qualify for a free or reduced-price school meal (Food Research and Action Center, 2002).

Special Milk Program

The Special Milk Program (SMP) is also administered by the Food and Nutrition Service at the Federal level and state education agencies at the state level. It provides milk to children in schools, childcare institutions, and eligible camps that do not participate in other Federal child nutrition meal service programs. Schools in the NSLP and SBP may participate in the SMP to provide milk to children in half-day pre-kindergarten and kindergarten where they do not have access to the school meal programs. Each half-pint of milk served is reimbursed at a set rate. The net purchase price of milk is reimbursed to school districts that receive their milk free. Expansion of the NSLP and the SBP have substantially reduced this program since its peak in the 1960s (USDA, 2002c).

Accommodating Children with Special Dietary Needs

Regulations governing the NSLP and SBP say substitutions must be made to the regular meal for students who are unable to eat school meals because of their disabilities, when that need is certified by a physician. The physician statement must identify the student's disability and why the disability restricts the student's diet, the major life activity affected by the disability, the food(s) to be omitted from the diet, and the food or choice of foods to be substituted. Section 504 of the Rehabilitation Act of 1973 delineates physical or mental impairments that may substantially limit one or more major life activities. For instance, students with life threatening food allergies will require a 504 accommodation plan. The Individuals with Disabilities Education Act (IDEA) requires that food adaptations be listed on a student's Individualized Education Plan (IEP). When nutrition services are required under a student's IEP or a 504 plan, food service personnel need to be involved early in the process regarding special meals and meal adaptations (USDA, 2001).

Team Nutrition

USDA studies in 1993 found the need for training and technical assistance for school food service professionals and for nutrition education for students. As a result, Team Nutrition was developed by the FNS. It is implemented through three behavior-oriented strategies:

1. Training and technical assistance for food service professionals to serve meals that look and taste good and meet nutrition standards;
2. Education about nutrition that is multifaceted and integrated for children and parents; and
3. Involvement of school administrators and other school and community partners to encourage their support for healthy eating and physical activity.

In addition, six communication channels are utilized. These include food service initiatives, classroom activities, school-wide events, home activities, community programs and events, and media events and coverage.

Team Nutrition initially began by inviting schools to volunteer. Emphasis is now placed on working through state agencies to recruit schools. Team Nutrition has produced many products and promoted various activities. A list and description can be found at <http://www.fns.usda.gov/tn> (USDA, 2002).

RATIONALE

The federally funded school meal programs provide a safety net for students who are nutritionally deprived. The provision of nutritious meals at school is an essential part of meeting daily nutrition needs for many students. Research shows poor nutrition has a direct correlation to poor school performance. A study assessing the relationship of having a school breakfast to psychosocial and academic functioning found students who increased their participation in the school breakfast program had significantly greater increases in their math scores and significantly greater decreases in the rates of school absenteeism and tardiness than children whose participation remained the same or decreased (Murphy et al., 1998).

ROLE OF THE SCHOOL NURSE

School nurses are in a unique position to advocate for school meals programs in their schools and for community programs. Within school districts meal programs can be enhanced by offering the range of options available through FNS. A school district offering only lunch and breakfast may additionally offer snacks during the school day and during before-and-after-school programs. School nurses can inform summer community programs about meals programs available to them to ensure their students are well nourished year round.

School nurses are key members of multidisciplinary teams serving students with 504 accommodation plans and individualized education plans. School nurses can advocate for the inclusion of school food service personnel on these teams for students with special dietary needs. School nurses work with parents to obtain the physician statement when food adaptations are needed. They serve as a liaison between the family, community health providers, and school personnel regarding adaptations needed by the student. School nurses provide any necessary training for school personnel, the student requiring the adaptation, and the student's peers.

Many school nurses have become actively involved in Team Nutrition Programs in their schools. Through Team Nutrition, school nurses may take an active role in several of the six communication channels utilized through the program, particularly classroom activities and community programs and events. School nurses bring their nutrition expertise to discussions about other foods served in the school setting. Some school personnel may be interested in the financial gains to the school district by serving non-nutritious foods such as soft drinks and candy. School nurses can advocate for the health benefits good nutrition brings, as well as the improved school attendance and academic gains. Finally, school nurses can track legislation at the national and state levels related to nutrition in schools and contact their legislators to offer their expertise.

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National Association of School Nurses

ISSUE BRIEF

School Health Nurse's Role in Education

PRIVACY STANDARDS FOR STUDENT HEALTH RECORDS

INTRODUCTION

Management of student health records is one of the most challenging responsibilities of school nurses. These responsibilities, usually shared with school district administrators, include the generation, maintenance, protection, disclosure, and destruction of students' school health records. Integrally related to these responsibilities are the legal and ethical principles of privacy, confidentiality, and consent. Complex to begin with, these record-management responsibilities and related legal precepts are frequently problematic for nursing professionals working with minor clients in school settings. This is particularly so today, for the reasons listed below.

- While school health records include personally identifiable health information of students and are generated by health professionals, they are, in most situations, considered education records, rather than health care records.
- Federal and state laws governing health and education records have different standards, language, requirements, and interpretations, even though the underlying principles have common roots. Today, more than in the past, the records include some of the same content.
- It is difficult to discern from the literature—due to the complexities involved—which law(s), if any, take precedence regarding students' health records (i.e., education versus medical, federal versus state).
- There are conflicts between health and education laws governing student records, confidentiality requirements, and access rights of parents and minor students.
- There are fundamental differences between legal standards in health and those in education related to adolescents' competence to give consent and make decisions for themselves. These differences sometimes cause practice dilemmas for school nurses (Schwab & Gelfman, 2001).
- Many school nurses are contract personnel, that is, they are hired by a health care agency to provide nursing services in the community's or county's public schools. Often the hiring agency, for example, a local health department, assumes that any records generated by the nursing staff are governed by health care laws, while the school district assumes that those same records are governed by education laws.
- School districts rarely have sufficient policies, procedures, and systems in place to ensure the privacy, security, and appropriate sharing of students' health and mental health information contained in today's health office and other school records.
- School nurses, like other school health professionals, are educated in the health care system and practice under health care laws. They rarely have pre-service preparation regarding education laws and standards relevant to the records they generate in schools, including student health and special education records.
- While the Preamble to the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) specifically *excludes*, as covered entities, schools and universities already covered by the Family Education Rights and Privacy Act (FERPA) (U.S. Department of Health and Human Services (USDHHS), 2000), there are both exceptions to that provision and a myriad of related legal and practice issues at the interface of HIPAA and FERPA. These have yet to be addressed through technical assistance by the U.S. Department of Health and Human Services or the U.S. Department of Education.

In addition to remaining questions regarding HIPAA and FERPA standards in relation to personally identifiable student health information and student health records, questions and conflicts remain between FERPA and the federal regulations governing records of patients in drug and alcohol treatment programs, and between FERPA and state minor consent-to-treatment laws. Both clarifications and remaining issues are briefly described below.

FERPA and School Health Records

The Family Education Rights and Privacy Act of 1974 (20 U.S.C. § 1232g) and its regulations (34 CFR § 99), as periodically revised by the U.S. Department of Education, set forth requirements for the protection and release of personally identifiable student information, including student health information. These requirements are applicable to all "education records" in public and private schools that receive any federal financial assistance. Education records are defined in the regulations as those records that are:

1. Directly related to a student; and
2. Maintained by an educational agency or institution or by a party acting for the agency or institution.

FERPA governs all student health records maintained by school employees or by contracted employees who provide "school health services" (Cheung, Clements, & Pechman, 1997), that is, health services directed to supporting students' participation and progress in school. These services are generally considered health promotion, health maintenance, and "related" or "support" services that enable students, especially those with special health care needs, to attend school, maintain (or improve) their health status during the school day, progress toward independence in self-care in the school setting, and achieve educational success. The matter of whether FERPA provides protection for oral communications of student information not otherwise documented in "student records" is not addressed in the regulations, remains subject to interpretation, and raises HIPAA-related issues. See Gelfman (2001) and Claghorn (2003). FERPA does not govern records of school-based health centers (SBHCs), although where a SBHC is fully operated by a school district, the applicable legal standards may require careful exploration and clarification by expert health and education attorneys.

The term "contracted employees" applies to school nurses who are employed by other agencies, including public ones, such as a town's department of health, and private ones, such as a "visiting nurse association," hospital, or other type of health care organization, when they are contracted by the school district (even via "handshake" across town departments) to provide "school health services" for the school district. The term may also include school-based health center personnel when, as employees of another community agency, they are contracted by the school district to provide "school health services" as support services for the school's student population. These contracted services are entirely separate and distinct responsibilities from the primary health care services (diagnostic and treatment services for parent-enrolled students) that are the primary mission of school-based health centers.

Health records are among the most sensitive records of both children and adults in our society and, traditionally, have been highly protected under law, medical practice standards, and the ethical codes of health professionals. Yet in schools, these records are often not distinguished from other types of education records (National Task Force on Confidential Student Health Information, 2000). FERPA provides a basic framework for protecting and disclosing student records, but leaves wide discretion to school districts for interpretation and implementation of the FERPA regulations. For example, FERPA permits school districts to define who in their district has a "legitimate educational interest" in accessing and disclosing various types of student records, including those generated by school health professionals, and those generated and released to schools with parental authorization by outside health care professionals.

FERPA does not require school district personnel to be trained in confidentiality requirements, nor does it impose consequences on school employees for non-permitted disclosures. Rather, it provides that, if a school district violates the requirements of FERPA, the district may be sanctioned through the loss of federal financial assistance.

HIPAA Privacy Rule and School Health Records

The Privacy Rule of the 1996 Health Insurance Portability and Accountability Act was published on December 28, 2000, by the U.S. Department of Health and Human Services, with an effective date of April 14, 2001. Significant modifications to the rule were published on August 14, 2002; compliance was required for most covered entities by April 14, 2003. This rule (45 CFR Parts 160 and 164) sets national standards for the privacy of individually identifiable health information and gives patients increased access to their medical records. Two other essential components of HIPAA address standard code and transaction sets for electronic transmissions of "individually identifiable health care information" (Transaction Rule) and security protections for protected health information (Security Rule) (USDHHS, 2003).

HIPAA and its regulations apply to health information created or maintained by: (1) health care providers who engage in certain electronic transactions, (2) health plans, and (3) health care clearinghouses (USDHHS, 2000). School-based health centers administered by covered entities and, in most instances, school-based health care providers employed by an agency other than a school district and who engage in certain electronic transactions, are subject to HIPAA. Schools and school health professionals whose records are covered by FERPA and who engage in certain electronic transactions (such as Medicaid billing) are likely covered by the HIPAA Transaction Rule, but not the HIPAA Privacy Rule (Bergren, 2003; Campanelli et al., 2003). Schools that receive no federal financial assistance and the health professionals that work in them may or may not be directly subject to the HIPAA Privacy Rule but, in any event, are advised to employ HIPAA standards as minimum criteria for practice.

In public schools, and non-public schools covered by FERPA, general implications of the HIPAA Privacy Rule for student health records include the following:

- The fundamental ethical and legal principles underlying FERPA and HIPAA are the same. FERPA protects student information in education records, while HIPAA protects individually identifiable health information, in any form, that is used or disclosed by a covered entity.
- HIPAA privacy requirements, which are more detailed and directive than FERPA privacy requirements, provide useful reference standards for school district policy, procedures, and practices related to the protection and disclosure of student health information. Guidelines for developing school district policy and procedures, using HIPAA, FERPA, IDEA, and ethical standards, are currently being developed by the American School Health Association in collaboration with the National Association of School Nurses, National Association of State School Nurse Consultants, and a national task force comprised of 12 national organizations, with funding from the Division of Adolescent and School Health in the Centers for Disease Control (Schwab et al., 2004)
- The HIPAA Privacy Rule excludes from its definition of “protected health information” education records covered by FERPA. As such, student records in schools and school districts that receive federal funding are generally not subject to HIPAA privacy provisions (USDHHS, 2000, p. 82483).
- School nurses are HIPAA-covered entities if they engage in HIPAA transactions, but the FERPA-covered records they are responsible for are not covered by the Privacy Rule. Thus, the records that are transmitted are subject to the HIPAA Transaction Rule, but not the Privacy Rule (Bergren, 2003; Campanelli et al., 2003; Grimms & Cordy, 2002).
- Clarification is still required in many states regarding the permissibility of communications between students’ health care providers and school nurses about student health procedures that are mandated by state statute for public health policy reasons (e.g., immunization status, the results of health assessments that are required for school attendance, and communicable disease reporting). Some states have provided guidance or passed clarifying legislation.
- Education is required regarding the Privacy Rule provision that permits the disclosure of protected health information (PHI) by HIPAA-covered entities without specific informed consent, if the disclosure is for “treatment” purposes. Representatives of the Office of Civil Rights of the U.S. Department of Health and Human Services interpret the Rule’s language to permit disclosures of PHI to school nurses who are providing treatment to a student (Campanelli et al., 2003), because school nurses meet the definition of “health care provider” under HIPAA. Nevertheless, many providers and their attorneys believe that they cannot disclose PHI, even for treatment purposes, to noncovered entities, even other health care providers. This becomes a barrier to care and is especially critical when physicians, or other authorized prescribers, issue a “medical order” for a student to receive a medication or medical treatment in school and the nurse, according to the state’s Nurse Practice Act, may only carry out the treatment under the order of an authorized prescriber. The safety and efficacy of the treatment plan can be compromised if communication between the prescriber and nurse, related to a medical order and its execution in school, is hampered.

- Practice dilemmas continue for FERPA-covered entities related to conflicts between minors' legal rights to privacy in the health care system and parental rights to access and control the release of all education records of their minor children. HIPAA-covered entities, such as school-based health centers, have no such conflict, because HIPAA defers to state laws and professional practice standards in the health care community to determine when minors, rather than their parents or legal guardians, may give consent for the release of their own PHI (e.g., treatment for sexually transmitted diseases or drug and alcohol dependence). FERPA, however, does not recognize minor consent-to-treatment statutes, either in state or federal law. Thus, when student health records are covered by FERPA and a minor student consults the nurse for counseling or referral related to a health care need for which the minor student has the right under state law to consent to treatment, conflicts regarding documentation, access to, and release of related records remain. See Schwab and Gelfman (2001) for a more in-depth discussion of confidentiality, conflicts in the law, and related practice issues.

Other implications of the HIPAA Privacy Rule and related issues of importance to school nurses can be found in Bergren (2001a, 2001b, 2003, and 2004).

Federal Drug and Alcohol Confidentiality Regulations

Federal law and confidentiality regulations governing drug and alcohol treatment programs (42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2) apply to a student assistance program (SAP) within a school, if it "specializes, in whole or in part, in providing treatment, counseling, or assessment and referral services for students with alcohol or drug abuse problems" (Legal Action Center, 1996). These regulations protect the records of students who obtain services through an SAP team and prohibit their disclosure outside the team except under very limited circumstances (Legal Action Center, 1996). Conflicts remain between the confidentiality regulations and FERPA regarding parental access to such records (Gelfman & Schwab, 2001). Additionally, it is unclear whether, absent an SAP, the federal regulations apply to the record of a student referred by a school nurse to an outside community agency for assessment and treatment of a drug or alcohol problem. Nevertheless, individual states may have laws that apply to this circumstance.

State Minor Consent-to-Treatment Laws

Although extremely variable, most states have laws giving "mature" minors the right to consent to health care treatment for one or more types of health problems, including drug and alcohol abuse, sexually transmitted diseases, human immune virus (HIV), reproductive health, and mental health (Cohn, 2002). Because the right to consent to health care includes the right to determine whether, under what circumstances, and to whom the record of that care can be released, the mature minor who chooses to seek care under a mature minor statute or prevailing practice standards in the state has the right to privacy regarding that care. Conflicts exist when school health professionals refer students for health care to which the students have such a privacy right, because any record of the referral or related discussion with the student is also subject to FERPA, permitting parents to access all of their minor children's school records (Schwab & Gelfman, 2001; Siegler, 1996).

Role of the School Health Nurse

Although some conflicts and questions regarding legal standards remain, the underlying principles of federal and state health care and education privacy laws are remarkably similar. Furthermore, although FERPA governs education records as defined above, HIPAA provides more detailed and additional requirements, such as staff training and penalties for failure to follow the law. Similar provisions can and should be used to strengthen school district policies and administrative procedures governing student health information that is in oral, written, electronic, or another form, whether or not the districts are subject to HIPAA. School districts with school-based health centers operating in their buildings and those that bill Medicaid for school-based health services or otherwise do business with an entity covered by HIPAA are encouraged to employ HIPAA privacy standards, even if they are not required to do so by law. Such compliance demonstrates the district's respect for the sensitivity and confidentiality of student health information, augments their procedural compliance with FERPA, and enhances trust and communication among schools, parents, students, and health care providers.

School health nurses can provide leadership regarding the security and privacy of student health information in their school districts by:

- Becoming educated and staying current regarding relevant laws, regulations, and guidelines or technical assistance, both federal and state.
- Educating administrators and colleagues about relevant laws, regulations, and guidelines as they apply to school health records, whether oral, written, electronic, or in another form.
- Educating students and parents about their rights to privacy and the limitations to those rights, particularly in terms of health office procedures.
- Providing suggested language for policy and procedures that will enhance school district and staff compliance with the spirit and letter of the laws.
- Providing staff training, annually and as needed, on the legal and ethical principles of, and school district policy and procedures regarding, the privacy and confidentiality of student health information.
- Ensuring that health room procedures, records (electronic and paper), and equipment provide adequate security and privacy of health records, as well as appropriate internal sharing "for legitimate educational purposes."
- Using functional health problems (i.e., standardized nursing diagnoses) in combination with individualized Section 504 plans, individualized education programs, and/or individualized health care plans for communicating student health and safety needs to other staff. Functional health problems should be used in lieu of medical diagnoses, whenever appropriate (National Task Force on Confidential Student Health Information, 2000), and individualized plans should be distributed to appropriate staff instead of circulating a list of students with their medical conditions (Schwab & Gelfman, 2001).
- Notifying state health and education leaders and legislators about conflicts and problems that interfere with student services and safe nursing practice.

Of critical importance, school nurses need to collaborate with school medical advisors, school administrators, educators, other school health professionals and staff, parents, adolescent students, and community experts in ethics, privacy of health care information, and education records, to develop clear and specific policies and procedures based on law and ethics. School health advisory councils may provide excellent forums for addressing policy, procedure, and practice issues related to student health information. School districts need to consult with their attorneys regarding the implications of HIPAA for school operations, policies, and procedures. School nurses also need to promote and support local, state, and national initiatives to address and, where possible, resolve conflicts in the law.

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National Association of School Nurses

ISSUE BRIEF

School Health Nursing Services Role in Health Care

REDUCTION IN FORCE

INTRODUCTION

Currently, two issues compromise adequate staffing for school health services. First, a nursing shortage affects all areas of nursing, including the specialty of school nursing. As a result, competition for nurses occurs among health providers, with some prospective employers offering higher salaries, better benefits, and sign-on bonuses to entice applicants. School districts rarely offer such enticements to recruit staff. Second, the economic climate affects funding available to school districts. As educational systems face decreased revenues and increased costs, local boards of education are searching for ways to meet budget constraints. Services that are not mandated by law, as is the case with some nursing services, are frequently cut disproportionately, regardless of their benefit to students.

BACKGROUND

The nursing shortage today is different from shortages experienced in the past. Fewer nurses are entering the field, and acute shortages are already evident in certain geographic areas. This shortfall is expected to grow more serious over the next 20 years. The aging of nurses and nursing faculty is one of the most critical problems facing the profession. Registered nurses who are less than 30 years old represent only 10 percent of the total working nurse population. The average age of employed registered nurses is 43.3 years (National League for Nursing, 2002). The latest National Association of School Nurses membership survey found almost half of the nurses responding were over 50 years of age (Johnson, 2002).

The primary federal agency responsible for providing information and analysis relating to the supply and demand for health professionals, the Health Resources and Services Administration, has made the following projections for registered nurses for the years 2000 through 2020, based on the National Sample Survey of Registered Nurses. The shortage of registered nurses projected to begin about 2007 was already evident in 2000. In 2000, the overall shortage was 6 percent and projected to grow to 20 percent by 2015 and 29 percent by 2020. The increase in demand for nurses by 2020 is a result of a projected 18 percent increase in population (resulting in 50 million more people who will require health care), a larger proportion of elderly people, and medical advances that will increase the need for nurses. By 2011 the number of nurses leaving the profession will exceed the number who are entering. Factors affecting the supply of registered nurses include a declining number of graduates from schools of nursing, an aging registered nurse work force, a decline in relative earnings, and the emergence of alternative job opportunities. According to the survey, more nurses are currently graduating from baccalaureate programs than from diploma and associate degree programs (U.S. Department of Health and Human Services, 2002). However, according to the American Association of Colleges of Nursing, baccalaureate enrollment itself fell 2.1 percent in 2000, for the sixth year of decline in a row (Sigma Theta Tau International, 2001). An increase in baccalaureate-prepared nurses would be advantageous for school nursing, as the National Association of School Nurses recommends a minimum of a baccalaureate degree to enter the specialty of school nursing.

There are almost one-half-million licensed nurses not employed in nursing. Only 7 percent of these nurses are actively seeking employment. It is not known whether the other 93 percent are not employed or are working in other fields. Salaries may contribute to the declining supply of registered nurses. Registered nurses have seen no increase in purchasing power in the last nine years, even though actual salaries have increased. And, in the year 2000, the average elementary school teacher earned \$13,600 more than the average registered nurse. Most of the wage growth for registered nurses occurs early in their careers and tapers off over time. As potential for increased earnings diminishes, nurses may become educated in other fields. Projections for school nursing include a decrease of about 4,600 school nurses between 2000 and 2020 or .7 percent of the school nurse workforce. The only other employment setting projected

to have a decrease is public health nursing. All other areas, which include hospitals, nursing homes, ambulatory care, home health, occupational health, and nursing education, have projected increases (U.S. Department of Health and Human Services, 2002). For the same time period, the number of children under age 18 in the United States is expected to grow from 72.6 million to 77.2 million. Even with the increase, children will form a smaller part of our total national population decreasing from 25.5 percent in 2001 to 24 percent by 2020 (Child Trends Data Bank, 2003).

In addition to the declining registered nurse work force decreasing the availability of nurses to be hired by schools, shortfalls or limited growth in state budgets are decreasing funding available for school districts to hire school nurses. In 2003, all but one state reported a deficit. Predicted aggregate state deficits may increase to \$60 to \$85 billion nationally in 2004. This may force states to cut billions of dollars from education. At the same time, school districts are pressured to spend more money on programs to ensure student improvement. The No Child Left Behind Act (the latest update of the Elementary and Secondary Education Act) adds many new requirements for state and district testing, teacher qualifications, and data systems that are expensive to fund. The Individuals with Disabilities Education Act is still only funded at 17 percent of full funding, forcing states and local school districts to make up the difference (Council of Chief State School Officers, 2003; National School Boards Association, 2001). School boards are, therefore, faced with decisions regarding programs and staff that are not mandated, and that often impacts school nursing programs and positions.

RATIONALE

School nurses are necessary in the educational system, whether they are hired directly by school districts, as were the majority (over 80 percent) in the 2002 NASN membership survey, or by other entities such as health departments or hospitals (Johnson, 2002). The school nurse has a central management role in the implementation of school health services (American Academy of Pediatrics (AAP), 2001). School nurses provide services to the entire school population, including infants, pre-schoolers, children with special health needs, traditional students, and school staff (NASN, 2002a). As authorized by federal and state laws, children with chronic illnesses and varying disabilities are included in the regular classroom. The school nurse ensures that students' individualized health plans and emergency health plans are written and included with individualized education plans and Section 504 Plans so the students educational experience is maximized and health needs are adequately addressed (AAP, 2001).

A 2003 study supported by The Robert Wood Johnson Foundation found that American parents support health and health care in schools. Most of the parents surveyed thought schools were the only source of health care for uninsured students and felt care in school would help keep all students healthy (Center for Health and Health Care in Schools, 2003).

ROLE OF THE SCHOOL NURSE

School nursing practice must adapt to accommodate changes within the profession of nursing and financial constraints within local school districts. Community/school needs assessments can be done to assist in determining the most efficient and appropriate school health services for individual school districts (Igoe, 2000). School nurses have a two-fold duty to increase school nursing services for students. The first is to join the effort to increase the number of students entering nursing programs to increase the availability of future nurses, including school nurses. The second is to address funding for health services within school districts.

School nurses can contact their legislators at both the state and the federal level and ask them to support legislation to fund nursing education. The Nurse Reinvestment Act, which provides nursing scholarship money, funding to promote best practices in nursing care, public service announcements to encourage nursing careers, and funding for other initiatives, was signed by the President in August 2002 (American Association of Colleges of Nursing, 2003). It is important to maintain this funding.

School nurses have a unique opportunity to showcase their profession to the school community where they work. The day-to-day nursing services provided need to be visible to students, parents, and staff. Every opportunity needs to be taken to talk to students and communicate with families through newsletters and parent meetings regarding the many roles of the school nurse. School guidance counselors, in particular, need to be educated about the advantages and disadvantages of different nursing educational programs leading to a degree in nursing. Through their daily nursing practice, school nurses can model professionalism and commitment to the nursing profession, enthusiasm for the job, and caring for students (Denehy, 2000). In addition to helping recruit future nurses to the field, visibility has the added benefit of helping ensure job security. School nurses are less likely to be laid off during a budgetary crisis if they are highly visible.

Parents become strong advocates for increased school health programs when they know the valuable services provided by their school nurse (Brandt, 2002).

Current funding for school health programs, in addition to education dollars, may include tobacco settlement money and Medicaid reimbursement for administrative claiming and direct service (Igoe, 2000). The No Child Left Behind Act allows local uses of funds for programs to hire and support school nurses under "Title V, Innovative Programs", although many other programs and services compete for these funds (U.S. Department of Education, 2002). School nurses also need to explore other funding resources in areas such as nutrition and asthma. New school/community partnerships may need to be forged to access additional funding sources within communities (Igoe, 2000; Weaver, 2003).

School nurses who are involved in lawsuits resulting from downsizing efforts may be eligible for legal support through the NASN legal defense fund. This fund was established in 1986 to assist NASN members and affiliated school nurse organizations in legal cases involving school nursing issues of national significance. National significance is defined as having the potential for the issue to result in the setting of legal precedent or significantly advancing the practice of school nursing (NASN, 2002b).

The 52 million students in the United States need quality school health services. Failure to attain (at a minimum) or exceed (at an optimum), the nurse/student ratio at the recommended level will adversely affect many school health services programs. Many students will no longer have the chance to participate in wellness screenings such as those for hearing and vision, if they live in states that do not mandate these screenings. Health education provided by school nurses may need to be discontinued in some school districts. Students with chronic health conditions may receive inferior care without school nurse case management. School nurses need to use every opportunity "to draw attention to the work they do to keep students healthy and focused on learning" (Domrose, 2003).

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Issue Brief

INTRODUCTION

Registered professional school nurses (hereinafter referred to as school nurses) are in a unique position to support students to ensure that their individual healthcare needs are met both at school and on field trips. All students are encouraged to attend school and access the full curriculum, including participation in school-sponsored trips (also called field trips). Many students require medications, treatments, and planning for their health needs and potential health emergencies that may occur while the students are away from the school building. School nurses must be involved in the planning for all school sponsored trips to ensure that all students with healthcare needs may safely participate.

BACKGROUND

Field trips are offered by schools to enhance the educational experience of students or to reward class accomplishments. A trip may be as simple as a local excursion for just a few hours or as complicated as a multi-night trip to a different city, state or country. “The level of nursing or healthcare services required for a student in the classroom is, at a minimum, the same level of care that the student requires during school programs outside of the classroom” (Hootman, Schwab, Gelfman, Gregory, & Pohlman, 2005, p. 223). As the number of students with specialized healthcare needs increases, it is critical that all school systems develop policies to assure the provision of safe and competent health services for students while they are away from school buildings for school-sponsored trips.

It is estimated that in the United States, 26.6% of children have special healthcare needs (Van Cleave, Gortmaker, & Perrin, 2010). Of these children, 86% have prescribed medication, 52% require specialty medical care, 33% require vision care, 25% require mental health services, 23% require specialty therapies and 11% require the use of medical equipment (U.S. Department of Health and Human Services, 2008). There are three federal laws that provide important protection to students with disabilities. Section 504 of the Rehabilitation Act of 1973 and Title II of the American Disabilities Act of 1990 (ADA) are civil rights laws that prohibit discrimination against individuals with disabilities. The Individuals with Disabilities Education Improvement Act (IDEIA), reauthorized in 2004, mandates a free and appropriate education in the least restrictive environment for those students who qualify for special education services (U.S. Department of Education, 2011). All schools which receive federal monies are subject to follow Section 504 and the ADA act (Gibbons, Lehr, & Selekman, 2013). Many states have additional laws that provide supplementary protections for students.

RATIONALE

All children, including students with special healthcare needs have the right to fully participate in school-sponsored trips. It is the school’s responsibility to provide necessary accommodations so that all students can attend (Foley, 2013). Currently, the costs associated with providing these accommodations are the responsibility of the school district, and must be considered in the initial planning phases of a proposed school sponsored trip. To deny a student the right to participate in field trips discriminates against the student.

The student’s healthcare needs on field trips are determined through a collaborative process coordinated by the school nurse, reviewed annually and include a nursing assessment, the healthcare provider orders and information provided by the family (Moses, Gilcrest, & Schwab, 2005). An individualized healthcare plan (IHP) is developed

and outlines the plan for meeting the healthcare needs of the student at school and on field trips, and is utilized to create emergency care plans (ECP). A system should be in place to involve the school nurse in all planning phases of the field trip to ensure that all necessary accommodations are in place.

THE ROLE OF THE SCHOOL NURSE

The school nurse's knowledge about each student's healthcare condition and the individualized plan of care is utilized during the planning of all field trips. The school nurse should perform an individual health assessment and develop the IHP at the beginning of the school year to ensure safe care for students with medical needs throughout the school year including the potential for off campus school sponsored trips.

The school nurse has the nursing background to appropriately assess the proposed school sponsored trip to determine the accommodations needed to allow all students to safely participate in activities. The school nurse may assess the transportation method, what food will be served, what staff will be present, the layout of the planned visitation site, duration of the trip, and proximity to emergency medical care. The healthcare needs and accommodation for students with diabetes, asthma, food allergies, epilepsy, mobility disorders, urinary and bowel disorders, psychosocial disorders, intellectual disabilities, and other health conditions are considered by the school nurse when planning for the field trip. Behrmann (2010) states that "although children with food allergy have a serious medical condition, their allergy should not result in their exclusion from events, such as field trips" (p. 186). This should be true for all students with health needs.

Students with special healthcare needs may require medication to be administered or medical treatments during the trip as outlined in the IHP. Students may also have potential health emergencies that are addressed in the ECP. While parents/guardians of the student may be offered the opportunity to accompany the student on the trip, it cannot be mandated that they attend. If allowed by state law, State Nurse Practice Acts, and district policy/procedures, the school nurse may consider delegating some tasks to a non-nurse, school staff member such as a teacher, utilizing the American Nurses Association's *Principles of Delegation* and the National Council of State Boards of Nursing *Decision Tree - Delegation to Nursing Assistive Personnel* (ANA/NCSBN, 2006). A school nurse who is familiar with the students' health condition and treatment may need to accompany the student if the school nurse determines that medical care cannot legally or safely be delegated (Prenni, 2009), and an additional school nurse cover the school health office. If the school sponsored trip takes place in a different state, plans must be in place to meet the nursing license and practice laws of that state. The Nurse Licensure Compact (NLC) allows nurses to have one multistate license, with the ability to practice in both their home state and other party states. A nurse who holds a license issued by a state that is not a member of the NLC has a single-state license that is only valid in that state. They must request and receive permission to practice in another state (NCSBN, 2012). Even if a trip is in a compact state, the nurse must still know what that state nursing regulations/laws are and scope of practice accordingly regardless of whether she/he is delegating tasks to a non-nurse school staff member or actually attending the field trip and performing the necessary health services (NCSBN, 2011). Field trips can be some of the most memorable experiences for students. School nurses must work closely with administrators, school staff, families and students to ensure that the healthcare needs and safety of all students are provided for during school sponsored trips. As more children with specialized healthcare needs enter the school system, the role of the school nurse becomes even more critical in assuring the rights, safety and educational experiences for all students.

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Field Trips and Extended School Trips (Adopted: June 2000, Revised April 2006).

Issue Brief

INTRODUCTION

Registered professional school nurses (hereinafter referred to as school nurses) advance safe school environments by promoting the prevention and reduction of school violence. School nurses collaborate with school personnel, healthcare providers, parents, and community members to identify and implement evidence-based educational programs. The curriculum used should improve communication, behavior management, and conflict resolution skills. School nurses assess and refer at-risk students in need of evaluation and treatment for symptoms of aggression and victimization.

BACKGROUND

Violence is defined as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (World Health Organization [WHO], 2011, para. 2). School violence occurs on school grounds, on school-supported transportation, and at school-sponsored activities regardless of where the conflict originated. It includes fighting/ assaults (with or without weapons by two or more individuals); bullying; physical, sexual and psychological child abuse; dating violence; and violence against oneself (intentional non-suicidal self-injury) (Selekman, Pelt, Garnier, & Baker 2013). School violence can be reduced by advancing a school environment that supports a zero tolerance for weapons of any kind, a focus on anger management, and counseling for the victim, aggressor and bystanders (Johnson, 2009).

School violence has an impact on the social, psychological, and physical well-being of both students and staff, and disrupts the teaching-learning process through fear, absenteeism, or class disruption; and affects the victim, the aggressor and the bystanders (Johnson, 2009; Selekman et al., 2013). Robers, Zhang, Truman, & Snyder (2010) reported that in the 2008-2009 school year there were 1.2 million victims of crimes at school: 629, 800 violent school crimes and 38 school-associated violent deaths, 22 of whom were students. Five percent of students over age 12 reported that they were afraid of an attack or harm at school, and 7% of students avoided either a school activity or one or more places in the school because of fear of being attacked or harmed. Staff safety is also a concern, with 10% of teachers being threatened with injury.

Male students are at a higher risk of violent incidents resulting in death and non-fatal injuries (Kaya, Bilgin, & Singer, 2011). However, violence involving females has increased significantly; girls now account for 30% of juvenile arrests (Zahn et al., 2010). Dating violence, a pattern of actual or threatened acts of physical, sexual, and/or emotional abuse, perpetrated by an adolescent against a current or former dating partner, frequently occurs on school grounds and may include insults, coercion, social sabotage, and sexual harassment, in addition to threats and/or acts of physical or sexual abuse (A Safe Place, n.d.). Violence against oneself can take many forms, and these behaviors frequently have a psychological basis. Rather than an expression of violence, they are expressions of deep pain and the attempts to control or express that pain (Selekman et al., 2013). School shootings, while rare, are often committed by students or former students who experienced persistent bullying, persecution, threats, or injuries by peers (Reuter-Rice, 2008). The Centers for Disease Control and Prevention (CDC) (2010) found that violence and bullying may have a negative effect on health throughout life. Teens who are victims are more likely to be depressed, do poorly in school, have eating disorders, and engage in other unhealthy

behaviors such as using drugs and alcohol. Lesbian, gay, bisexual and transgender (LGBT) youth who experience high levels of school victimization in middle and high school report impaired physical and mental health in young adulthood, including depression, suicide attempts requiring medical care, sexually transmitted diseases (STDs) and risk of HIV (Russell, Ryan, Toomey, Diaz, & Sanchez 2011).

RATIONALE

School nurses have the expertise to assist students to develop problem-solving and conflict resolution techniques, coping and anger management skills, and positive self-images. School nurses possess the knowledge to be active members of crisis intervention teams to address violent situations in the school setting. School nurses can be involved in curriculum committees that identify and implement evidence-based intervention and prevention programs.

THE ROLE OF THE SCHOOL NURSE

The ultimate goal of the school nurse is the prevention of violence and the prioritization of safety for the students, staff and the school community as a whole. This involves providing education to the school community in problem solving and conflict resolution skills, recognizing early warning signs that lead to violence, and identifying factors outside of the school setting that might predispose a child to violent behavior or threaten student's safety. When violence occurs, school nurses are positioned to intervene, working collaboratively to change the dynamics of the crisis situation (Reuter-Rice, 2008). School nurses are able, individually and through their national association, to assess and address violent behavior (Jacobson, Reisch, Temkin, Kedroski, & Kuba, 2011).

School nurses are able to support the efforts of administration to provide and maintain security; to offer programs to parents that support building skills in the areas of communication, problem-solving, and monitoring of their children; and assist in the development of district and school discipline policy or code of conduct documents. School nurses are able to serve on school safety and curriculum committees, identifying, advocating and implementing prevention programs within the school community.

School nurse Interventions to prevent violence include the following:

- Facilitate students' feeling "connected" to the school community (Green, 2008).
- Engage parents in school activities that promote connections with their children, and foster communication, problem-solving, limit setting, and monitoring of children.
- Support activities and strategies to help establish a climate that promotes and practices respect for others and for the property of others.
- Support policies of zero tolerance for weapons on school property, including school buses.
- Advocate for adult monitoring in the hallways between classes and at the beginning and end of the school day (Blosnich & Bossarte, 2011), and the assignment of staff to monitor the playground, cafeteria, and school entrances before and after school.
- Serve as positive role models, developing mentoring programs for at-risk youth and families.
- Educate students and their parents about gun safety (Selekman et al., 2013).

When violence occurs, school nurse interventions to address violent behaviors include:

- Apply crisis intervention strategies that help de-escalate a crisis situation so that solutions can be identified.
- Identify and refer those students who require more in-depth counseling services.
- Participate in crisis intervention teams.

School nurses recognize the multiple factors that may increase or decrease a youth's risk of becoming a perpetrator or victim of school violence and school nurses are able to identify students at risk. The CDC (2011) identified potential risk factors and protective factors that may determine whether or not a student may become a perpetrator or victim, including individual and family characteristic.

Individual risk factors:

- History of violent victimization, emotional problems, and aggressive behavior
- Learning disorders, including ADD/ADHD
- Drug, alcohol or tobacco use
- Involvement in gangs
- Social rejection by peers
- Lack of involvement in conventional activities
- Poor academic performance
- Low commitment to school and school failure
- Exposure to violence and conflict in the family
- Low emotional attachment to parents or caregivers

Family risk factors:

- Harsh, lax or inconsistent disciplinary practices
- Parental substance abuse or criminality
- Poor monitoring and supervision of children

Protective factors:

- Connectedness to family or adults outside the family
- Ability to discuss problems with parents, guardians or adults outside the family
- Frequently sharing activities with parents, guardians or adults outside the family
- Consistent presence of a parent during at least one of the following: when awakening, when arriving home from school, at evening mealtime, or going to bed.
- Commitment to school
- Involvement in social activities

Overall, school nurses promote violence prevention by assisting in the creation of a school environment of safety and trust where students are assured that caring, trained adults are present and equipped to take action on their behalf; engaging in classroom discussions that facilitate respectful communication among students and staff; and advancing education of the school community that builds skills in communication, problem-solving, anger management, coping and conflict resolution (Jacobson et al., 2011). Advancing a peaceful school environment requires time, attention to detail, and community education. The individual, family, and society all have significant roles in successful violence prevention in the school community (Kaya, Bilgin, & Singer, 2011).

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Role of the School Nurse in Violence Prevention (Adopted: September 1994; Revised: June 1995; June 2000; November 2005) and the Issue Brief, Violence, School (2005)



National Association of School Nurses

ISSUE BRIEF

School Health Nursing Services Role in Health Care

SECTION 504 OF THE REHABILITATION ACT OF 1973

INTRODUCTION

Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 § 504) is a federal civil rights law that prohibits discrimination against individuals on the basis of disabilities and guarantees access to federally funded programs, including public school, for disabled individuals. The Office for Civil Rights (OCR) is the federal administrative agency within the U.S. Department of Education charged with implementing the law and monitoring compliance.

The law defines an individual with a disability as one with a physical or mental impairment that substantially limits one or more major life activities. For students who are eligible under Section 504, schools must make appropriate accommodations to eliminate barriers to the students' participation in school and school activities. Implementation of Section 504 provides disabled students with the same access to educational opportunities provided to their non-disabled peers and supports them in achieving positive health and educational outcomes.

BACKGROUND

Section 504 of the Rehabilitation Act of 1973 protects the rights of individuals with disabilities to access programs and services that are supported by federal funds, including public schools. The Section 504 regulations provide a framework for school district policy and procedure.

- Institutions receiving federal funds, including public schools, must comply.
- Schools must identify students who may have disabling conditions (Child Find).
- Schools must establish standards and procedures for evaluation of handicapped students and eligibility determination.
- Schools must meet individual needs of disabled students to insure they have the same access to education as non-disabled students.

The law stipulates that identification of students and determination of their individual eligibility for accommodations under Section 504 is to be a collaborative process accomplished by a school-based 504 team. Anyone can make a referral for evaluation of a student's eligibility. However, OCR has stated in a staff memorandum (OCR memorandum, April 29, 1993) that the school district must also have reason to believe that the child needs services under Section 504 because of a disability.

The 504 team:

- Must comprise persons knowledgeable about the student, the disability, and possible accommodations, including the parents, if they choose to participate, and the student, if appropriate;
- Must determine eligibility under Section 504; and
- If eligibility is confirmed, must design an accommodation plan based on specific individual needs of the student.

To be eligible for accommodations under Section 504, a student must have a physical or mental impairment that substantially limits a major life activity.

Section 504 defines “physical or mental impairment” as:

- Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitor-urinary; hemic and lymphatic; skin; and endocrine,
- Or, any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

“Major life activity” means functions such as: caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Section 504 does not specifically define “substantial limitation.” However, the school-based 504 team can look to the Americans with Disabilities Act (ADA) for guidance. The ADA protects the rights of disabled individuals in the workplace and states that an individual is “substantially limited” by a disability if,

- He/she is unable to perform a major life activity that the average person in the general population can perform, or
- He/she is significantly restricted as to the condition, manner, or duration under which the average person in the general population can perform the same major life activity.

In the school context, the student in question would be compared to an average student of the same age or grade level in the general population.

The school 504 team is charged with applying the definition criteria above and determining whether or not a student has a physical or mental impairment that substantially limits a major life activity. The team must answer three questions:

1. Does the student have a physical or mental impairment?
2. Does the impairment impact one or more major life activities?
3. Does the impairment **substantially limit** one or more major life activities?

When students are identified, assessed, and determined to be eligible for accommodations under Section 504, the school 504 team must create an individual accommodation plan (IAP or 504 Plan). Section 504 does not outline specific plan components, but suggests that the plan should be written. The key elements of an individual accommodation plan are strategies based on the student’s individual needs that will enable the student to access a free and appropriate education in the least restrictive environment. Accommodations under Section 504 may include related aids and services, such as school health services, and may include specialized instruction.

RATIONALE

Identifying students with physical and mental health disabilities is the first step in prohibiting discrimination on the basis of disability in public schools. By identifying eligible students, school nurses play a crucial role in both preventing further health complications and providing students with disabilities the same opportunities as non-disabled students to benefit from their education.

School districts have inconsistently implemented the requirements of Section 504 because, unlike IDEA, there is no funding attached to the law and interpretation of the law and its requirements were initially unclear. Passage of the Americans with Disabilities Act in 1990 heightened the awareness of school districts and parents of children with disabilities, who both became increasingly aware that Section 504 could offer certain protections and opportunities for disabled students. School districts are now more informed of their obligations under Section 504, and so are parents, who have begun to request that schools provide appropriate accommodations for their children. Some students with disabilities still are subjected to discrimination in public schools, particularly in communities where parents have fewer resources and less information is available to them.

Section 504 implies best practice for schools:

- Policy and procedures for determining eligibility and developing 504 Plans for eligible students,
- Well-informed, collaborative 504 teams,
- Procedures for meeting special needs of students with impairments who do not qualify for a 504 Plan

THE ROLE OF THE SCHOOL NURSE

The professional school nurse is an integral member of the 504 team. The school nurse routinely identifies students with physical or mental disabilities and notifies the school that certain students may require accommodations or other services under Section 504. The school nurse is the professional who gathers and interprets health information and who therefore, has the most information about students' health conditions. He or she routinely develops Individualized Healthcare Plans (IHP) collaboratively with student, family, school staff, community, and health care providers as appropriate (NASN/ANA, 2005). The school nurse is a provider of direct school health services according to the IHP and continuously monitors the health status of students.

The school nurse role as a 504 team member includes:

- Becoming familiar with school district policy and procedures related to Section 504 Regulations;
- Obtaining from physician(s) information related to diagnosis, nature of disability and related problems, including effects of medications, and then providing clarification to the team;
- Explaining the IHP nursing document to the team, if an IHP has been written;
- Explaining observed impact of health conditions on student's school participation; and
- Recommending health-related accommodations so that the eligible student has equal access to education.

For students who need health-related accommodations at school, the school nurse develops an IHP, a nursing document. Like the Section 504 processes, the IHP process is collaborative and includes parents, school staff, and health care providers (National Association of School Nurses, 2005). Many districts consider the IHP to be a 504 Plan in the cases where a student needs only the health-related accommodations outlined in the IHP to access education. The IHP then, is subject to the regulations of Section 504. Therefore, once the 504 team has determined eligibility for an individual student, the team then can determine whether academic accommodations are also needed for the student to access education. If classroom or academic accommodations are needed, then those accommodations can be written as the 504 Plan and the IHP can then be added to the 504 Plan as an accommodation.

If a student needs an IHP for health-related accommodations to access education, then the student is likely to be determined to be Section 504 eligible. An example is the student with diabetes who must monitor blood glucose levels and administer insulin during the school day. Blood glucose monitoring and management would require classroom accommodations such as providing an opportunity for the student to be caught up on what was missed when she/he was experiencing a low blood glucose level and could not attend to or comprehend what was being taught or, providing extra time to complete a standardized test because she/he may need breaks to check blood glucose levels during examinations.

A student may also have an IHP because she/he receives medication at school to control symptoms of attention deficit disorder (ADD). If the administration of medication is the only accommodation that the student needs to access education and there is already a procedure in place for administration of medication, then the student would not need a 504 Plan, and the 504 team would not determine that the student is Section 504 eligible. On the other hand, if that student with ADD also needs accommodations provided by the teacher in the classroom, then the student would need a 504 Plan and would be eligible under Section 504.

Once the 504 Plan has been written, the 504 case manager monitors student progress. The case manager for the 504 Plan is the person who is most knowledgeable about the disability and the accommodations. If the student receives medication at school to control symptoms and accommodations are only health-related, the school nurse is the case manager. If the accommodations are primarily academic, then a classroom teacher may be the most appropriate case manager. The school nurse case manager monitors a student's response to health-related accommodations, communicates with parents and health care providers, modifies the IHP as needed, and calls a meeting of the 504 team

to make changes to the 504 Plan as needed. The law mandates that school districts reevaluate a student who has a 504 Plan whenever there is "any significant change in placement" (34 C.F.R. pt. 104.35, Paragraph (a), *Preplacement evaluation*), and otherwise establish policies "for periodic reevaluation of students who have been provided special education and related services" (34 C.F.R. pt. 104.35, Paragraph (d), *Reevaluation*). According to 504 regulations, "A Reevaluation procedure consistent with the Education for the Handicapped Act [IDEA] is one means of meeting this requirement" (34 C.F.R. pt. 104.35, Paragraph (d), *Reevaluation*). Periodic reevaluation consistent with IDEA requirements would occur every three years, however, an annual review is best practice.

The school nurse also plays an important role in interpreting Section 504 for administrators and parents of students with health-related disabilities. Parents often request 504 Plans (in addition to an IHP) because they want greater legal protection and recourse, and if the school district agrees that the student needs services under Section 504, they are entitled to the Section 504 process. Following Section 504 procedures is of primary importance to OCR, and parents can file a complaint with OCR if they feel that their student is not receiving rightful services for a disability.

Section 504 Accommodation Plans are created to eliminate barriers to participation in academic programs and to social development for disabled students. The student's impairment does not have to impact learning (reflected in documentation of academic performance) for a student to be eligible for services under Section 504, but the disability must substantially limit a major life activity. Although all disabilities may ultimately impact learning without accommodations, poor grades or academic performance below grade level need not be present for a student to be eligible for services under Section 504. School nurses should be members of 504 teams and not only in cases of chronic disease. The school nurse IHP document should stand as the 504 Plan when the accommodations are only health-related and adherence to the IHP should be an accommodation included in the 504 Plan for eligible students who also have academic accommodations.

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Self-Administration of Rescue Inhalers for

Asthma in the School Setting

Issue Brief



INTRODUCTION

It is the position of the National Association of School Nurses to support students with asthma who actively participate in the self-management of their condition and in self-administration of prescribed, inhaled, quick relief bronchodilator asthma medications (rescue inhalers).

The decision to allow a student to carry and self-administer rescue inhalers should be made in adherence to state laws and policies related to permitting students to carry and self-administer medication. Written permission from the parent must be accompanied by documentation from the health care provider confirming that the student has the knowledge and skill to safely possess and competently self-administer a rescue inhaler. In the school setting, the school nurse is the most appropriate professional to assess the student's ability to demonstrate competency in carrying and using the medication safely and appropriately.

BACKGROUND

- The prevalence of asthma is 7.1 million or 9.6% of children under 17 years of age in the United States (Bloom, Cohen & Freeman, 2010).
- Asthma can be a life-threatening disease if not properly managed. While deaths due to asthma are rare among children, the number of deaths increases with age. In 2006, 131 children under 15 died from asthma compared to 653 adults over 85 (Heron et al., 2009)
- Asthma is the third leading cause of hospitalization among children under the age of 15 (DeFrances, Cullen & Kozak, 2007). Approximately 32.7 percent of all asthma hospital discharges in 2006 were in those under 15; however, only 20.1% of the U.S. population was less than 15 years old (ALA, 2010a).
- Asthma is one of the leading causes of school absenteeism (NCCDPHP, 2009).
- In 2008, asthma accounted for an estimated 14.4 million lost school days in children with an asthma attack or episode in the previous year (ALA, 2010a).

Rescue inhalers are emergency medications and must be dispensed quickly to effectively treat asthma symptoms. Legislation that protects a student's right to carry and self-administer asthma medications in schools is now in effect in all 50 states (ALA, 2010b). Most of the laws regarding self-administration of inhalers do not distinguish between the kindergarten and 12th-grade student. Elementary children, especially those under 7 years of age, should be supervised with their inhaled medications (Flower & Saewyc, 2005). Determination of whether a student may safely carry and self-administer a rescue inhaler should consider the child's age and developmental level, his or her ability to demonstrate competency in using the medication safely and appropriately, the recommendations of the parent and health care provider, and the availability of a school nurse.

RATIONALE

Students who carry and self-administer their inhalers properly can prevent or reduce the severity of their asthma episodes (Moore, Uyeda, Cuevas, & Villanueva, 2010). In addition, self-administration of rescue inhalers using proper inhalation technique can be a very important step in a student's overall asthma management.

The decision to allow student self-administration of a rescue inhaler is best determined by (1) overall supervision by the professional school nurse with appropriate, periodic nursing evaluation of the student's technique and self-assessment skills, and supervision of any delegatory functions that may apply to unlicensed assistive personnel, (2) the consent of the parent/guardian, and (3) collaboration with the prescribing provider who should also be confirming the student's ability to safely and appropriately use his or her rescue inhaler as outlined in the student's asthma action plan.

For the majority of children with asthma, proper monitoring and management ensures that the child is able to participate in normal, everyday activities. Rescue inhalers are prescribed medications that act rapidly upon the airway to treat acute asthma symptoms. Timely and rapid administration of the rescue inhaler is crucial for a student with asthma. Because children spend a good portion of their day in the school setting, students must have appropriate access to rescue medication to control asthma at school. Students who carry inhalers may not always have one when needed, so it is important to keep a personal back-up inhaler in the health office.

School district medication policies and procedures must be developed to provide the best quality of care for students with asthma while at the same time ensuring the safety of all students. School district medication policies/procedures should include criteria for the safe and appropriate implementation of self-administration of asthma rescue inhalers.

THE ROLE OF THE SCHOOL NURSE

The registered nurse in the school plays a vital role in developing and implementing asthma action plans, assessing students' ability to safely self-manage their asthma, and monitoring individual student's level of asthma control. The school nurse provides ongoing education to students on proper inhalation technique and recognition of symptoms that require urgent intervention, provides asthma education to school staff as well as identifies when a student's rescue inhaler is not effective and requires Emergency Medical Services (EMS).

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Asthma Rescue Inhalers in the School Setting, The Use of (Adopted: 1993; Revised: 1999, 2005)

Issue Brief

INTRODUCTION

Animals that provide for the physical and mental well-being of humans are perhaps the most admired of all working animals. “Service animal” is a term that distinguishes those animals that serve individuals with physical or mental disabilities, usually on a one-on-one basis, from pets or other types of skilled animals, such as police dogs (Ensminger, 2010). The term, though primarily legal, is used quite broadly in today’s society, and a request to bring a service animal into the school setting presents questions due to the complex disability discrimination laws, insufficient medical and psychological data concerning service animal benefits, and difficulty distinguishing between a service animal and a household pet.

The registered professional school nurse (hereinafter referred to as school nurse) is the school’s healthcare representative on site (AAP, 2008), and has a unique role in providing school health services to children and young adults with special healthcare needs, including those with chronic illnesses and disabilities who may require coordination of care and services. School nurses actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy and learning. They are leaders in development and evaluation of school health policies and programs, through coordination of linkages between the medical home, family and school, and are, therefore, valued assets in planning efforts for “service animals” in schools.

BACKGROUND

In the past 20 years there has been an expansion of the diversity of service animals being utilized by persons with disabilities, with some confusion as to what truly is a “service animal”. Effective March 15, 2011, the Americans with Disabilities Act (ADA) regulations define a service animal as “a dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability” (USDJ, 2011). In addition there is a new separate provision which includes miniature horses in the definition of a “service animal” if the miniature horse has been individually trained to do work or perform tasks for people with disabilities (Jacobs, 2011). Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a service animal has been trained to provide must be directly related to the person’s disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA (USDJ, 2011). Children who may require a service animal in school are supported by the ADA regulation, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), Individuals with Disabilities in Education Act (20 U.S.C. 1400 et seq), as well as state and local laws.

RATIONALE

School districts recognize that service animals may be used to provide assistance to some students/staff with disabilities, which includes the presence of the service animal in the school, on school property, including school buses, and at school activities. Schools have a legal responsibility to provide planning and services for children with special healthcare needs, including allowing service animals into schools. Planning promotes quality care for students with special healthcare needs in school and enhances the student’s academic success.

Communication between the family, school, and healthcare provider is critical and may uncover adaptations or alternatives to the service animal’s presence in schools. Some initial questions to ask once the request for a service animal has been made include the following:

- Is the service animal required because of a defined disability, and will the animal impact the student’s

academic and behavioral functions to support his or her education?

- Does the student need the service animal for equal access to educational services and programs?
- What work or task has the service animal been trained to perform?
- How will the service animal alert its handler/student to an impending incident?

School district policy in regard to service animals should address the following:

- Compliance with current federal, state and local laws regarding service animals in schools.
- Written documentation from a veterinarian that the service animal is in good health and properly vaccinated. Although such documentation is not legally required, it helps confirm that the animal is safe to be around other students at the school (Virginia Department of Education, 2011).
- Provision of training for staff and students in rationale for, and interaction with, the service animal.
- Education of students, staff members and the community on the role of service animals and the laws permitting them access to public places.
- Control of the service animal in school. "Service animals must be harnessed, leashed, or tethered unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls" (USDJ, 2011, para. 6).
- Schools may exclude any service animal if that animal is out of control, the animal's handler does not take effective action to control it, or the animal is not housebroken (USDJ, 2011).

Other factors that the school should consider include the following:

- According to the law (USDJ, 2011), schools are not responsible for care, including elimination needs, food or a special location for service animals. The animal's owner/family is responsible for the "care and supervision of the service animal" (USDJ, 2011). However, many students who have service animals are not able to provide care for their animal at school. Communication and planning between school and home are essential in making adaptations to this rule (Minchella, 2011).
- When there is more than one service animal in a school building, special arrangements should be made so the animals can meet each other in a controlled setting.
- When a miniature horse is the service animal, the type, size, and weight of the miniature horse and whether the facility can accommodate these features without compromising legitimate safety requirements that are necessary for safe operation, should also be considered. Other requirements which apply to service animals, shall also apply to miniature horses (USDJ, 2011).

Service animals in schools may create additional issues and questions for schools to consider, such as triggering allergies in some students/staff, fear of safety to self or others, increased liability for the school district, and general animal care issues, such as feeding, grooming, and elimination. Planning for a service animal in school depends on multiple factors and requires individualized preparation.

THE ROLE OF THE SCHOOL NURSE

The school nurse identifies student health issues and special needs that are relevant to the student's educational progress and recommends services or program modifications that the student may need or require. The school nurse is also the link between the student/parents and other school personnel, and between school personnel and the community health care providers and resources. Communication and planning are essential in supporting the student with a service animal. The school nurse plays a key role in facilitating this communication and planning process.

School nurses have a community health-based understanding of the stressors of caring for a child with special healthcare needs, and school administrators often rely on the school nurse's broad knowledge base and ability to anticipate concerns and to coordinate and develop plans for the student's health care needs during the school day. Those plans may involve having a service animal and may indicate what role the service animal will have in interacting or alerting the student or staff to a potential emergency situation.

A multi-disciplinary approach is required to determine eligibility for services within the educational system. The school nurse is the leader in educating, advocating, supporting placement of, and evaluating the success of these services. Based upon school policy, the building administrator, along with input from the school nurse, will determine the appropriateness of the service animal in the school.

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National Association of School Nurses

ISSUE BRIEF

School Health Nursing Services Role in Health Care

Substance Use and Abuse

INTRODUCTION

Substance use and abuse is a two-pronged problem impacting students from pre-school through high school. Children of all ages may experience problems either related to living in a drug or alcohol affected home or to abusing substances themselves. Family problems can include child abuse, fetal alcohol syndrome, a change in the family dynamic that co-opts children in keeping the family secret, depression, somatization, feelings of guilt, learning and academic problems, as well as genetic and environmental factors that increase their own probability of substance abuse (Sullivan, 1995; Kinney, 1996). Problems related to personal substance use and abuse can include legal difficulties, academic difficulties, truancy, dropping out of school, family difficulties, addiction, health problems, and morbidity and mortality related to accidental injury, homicide and suicide (Sullivan, 1995; CDC, 2000). These students put their academic achievement at risk and can be a profound challenge to the school teams that serve them. A number will present with behavior problems, health problems, or neglect (Sullivan, 1995), which often come to the attention of the school nurse. A significant number are involved in tobacco, alcohol, and marijuana use (CDC, 2000) which represent a risk for tobacco-related health problems, alcohol addiction, alcohol-related morbidity and mortality, and problems related to marijuana use (Hubbard, Franco, & Onaivi, 1999). Because school nurses often participate in primary, secondary, and tertiary prevention activities in schools, they appear approachable and informed to students seeking help. Therefore, the school nurse plays a key role in identification, support, and possible referral of students impacted by substance use and abuse.

BACKGROUND

- Tobacco, alcohol, and marijuana use rates have remained steady or slightly decreased, but still impact a significant number of students (Johnston, O'Malley, & Bachman, 2002).
- 36.6% of 8th graders have used tobacco in their lifetime, down from a high of 49.2% in 1996. 61% of 12th graders have used tobacco in their lifetime, down from a high of 65.4% in 1997 (Johnston, O'Malley, & Bachman, 2002).
- Students reporting being drunk at least once in their lives number 23.4% of 8th graders and 63.9% of 12th graders (Johnston, O'Malley, & Bachman, 2002).
- 32.2% of students report having drunk more than a few sips of alcohol before the age of 13 (CDC, 2000).
- Among 8th graders, 20.4% report use of marijuana; 49.0% of 12th graders report marijuana use (Johnston, O'Malley, & Bachman, 2002).
- Alcohol use is associated with the three main causes of death for teens: accidents including motor vehicle accidents, suicide and homicide (CDC, 2000).
- Within 30 days preceding the NIH survey, 33.1% of students reported that they had ridden at least once with a driver who had been drinking alcohol (CDC, 2000).
- 13.1% of students reported having driven a car within the previous month after using alcohol (CDC, 2000).
- Additionally, 24.8% of teens reported having used drugs or alcohol at the time of their last episode of sexual intercourse (CDC, 2000).
- 25% of students are estimated to live in homes affected by alcohol abuse (Grant, 2000).
- Drug addiction in the home is associated with severe and growing levels of child abuse and neglect (CASA, 1999).

In our culture, alcohol and drug use is often seen as part of growing up or a rite of passage. In fact, it is a significant risk behavior that is associated with other risk behaviors such as impaired driving or sexual intercourse. Teens need information and support to help them with the decision-making around these issues. They may require support and referral for alcohol abuse or problems related to drug and alcohol use, such as abuse or neglect.

RATIONALE

School nurses are in a unique position to provide primary, secondary, and tertiary prevention services in substance use and abuse prevention. Their daily contact with students allows the nurse to identify at-risk students. Students may present to them with somatic complaints, signs of depression, or concerns about their own chemical use. The educational and administrative team often shares concerns with the nurse. The nurse often has had some contact with the parents or guardians. School nurses are uniquely aware of community-based referral resources and are able to coordinate with the parents and the school team to meet the needs of the child. Consistent with the NASN Issue Brief, *Role of the School Nurse* (NASN, 2002), nurses may initiate individual- or classroom-based health counseling and education to provide students with knowledge and skills in decision making, personal values identification, problem-solving, and communication, support, and contact with a caring adult, all of which strengthen the student's self-esteem.

ROLE OF THE SCHOOL NURSE

School nurses recognize that students may experience alcohol and other drug problems *either* through use by their significant adults or siblings *or* through the student's own use. Either scenario can impact the child's coping, academic achievement, and health. School nurses actively support substance use and abuse prevention when they:

- Provide primary prevention/education to individual students and classrooms in an age specific, culturally and developmentally appropriate way, utilizing the proven approaches to prevention including enhancement of protective factors and reduction of risk factors; practicing of life skills; interactive teaching methods; inclusion of parents or caregivers; coordination with community-based prevention; and adaptation to the community's specific needs (NIDA, 2001).
- Recognize that students living in alcohol-affected homes *may* have a multiplicity of alterations in academic achievement, social skills, affect, and health. At the same time, not all student problems in these areas will be related to chemically impaired parents. Additionally, some students living in chemically affected homes will have sufficient additional supports to avoid many negative consequences often associated with chemically dependent homes (Sullivan, 1995).
- Provide support to the student without enabling or reinforcing the child's perception of being responsible for the family's situation (Sullivan, 1995).
- Refer those students that need evaluation and treatment for abusive or addictive chemical use and concurrent mental health problems, including suicide risk. The school nurse needs to be able to network effectively with the student, the parents/guardians, the school team members (including counselors), and community agencies to build support for referral.
- Make appropriate referrals to agencies such as Social Services, Drug and Alcohol Treatment Services, Mental Health services, and the Child Protection Team.
- Respect the confidentiality of student and problem-solve the ethical dilemmas often associated with substance use and abuse issues.
- Support and participate in community prevention efforts.

Students impacted by substance use and abuse have diverse needs. Substance use and abuse problems require interventions aimed at students from pre-school to high school utilizing primary, secondary and tertiary prevention strategies. The school nurse's broad range of nursing knowledge along with her or his unique knowledge of the schools served combine to meet the needs of students in this complex area.

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June 2003



National Association of School Nurses

ISSUE BRIEF

School Health Nursing Services Role in Health Care

THE ROLE OF THE SCHOOL NURSE IN THIRD PARTY REIMBURSEMENT

INTRODUCTION

Children come to school with a variety of health conditions, varying from mild health issues to multiple, severe health problems that have a profound and direct impact on their ability to learn. The school nurse plays a vital role in the provision of health care services in school to children with these health conditions. Many school districts are developing Third Party Reimbursement programs to support funding for the provision of school nursing services. Nursing service is a reimbursable health care service in home care, hospitals, and other health care settings. It is the belief of the National Association of School Nurses that comparable health care services delivered in school settings should be reimbursed.

BACKGROUND

Increasing Demands for the Delivery of Health Care Services in Schools

Factors impacting the increase in the delivery of health care services in schools include:

- Federal legislation addressing health-related services to children and adolescents in school (Section 504, 2005; IDEA, 2004).
- An increase in the number of children with complex health problems.
- Treatment regimens reflecting evidence-based medical practice have changed care and management required during the school day. For instance, type I diabetes now requires closer monitoring and more injections.
- The number of children with asthma is increasing, and the need for intervention and management during the school day is increasing.
- Lack of health insurance coverage results in schools becoming the only source of health care for many children and adolescents.
- An increase in the required number of immunizations for school attendance. Schools may provide immunizations in order to eliminate missed school days and assist children and adolescents in being compliant with the immunization laws.
- An increase in immigration has led to a need for tuberculosis screening and follow-up of positive screening results.
- An increase in children without legal documentation, which results in barriers to their accessing health and dental care.
- Cultural, language, and transportation barriers result in problems navigating a very complex health care system so children arrive in school with unmet health care needs.
- Poverty and the complex variables associated with poverty often delay treatment of health conditions impacting attendance, time on task, and readiness to learn.
- Health disparities for children of color that result in unmet health needs.
- Working families with very limited time for clinic appointments, which results in delays in seeking care.

These factors, together produce the current increased demands on school systems to provide health care services that are, for the most part, uncompensated by the health care system.

Reimbursable Health Care Services in Schools

Many health care services delivered in schools are reimbursable. The Centers for Medicare and Medicaid publication, *Medicaid and School Health: A Technical Assistance Guide, August 1997 (The Guide)* (CMS, 1997) describes service categories that could typically be covered for school providers:

- Physicians' services and medical and surgical services of a dentist (Act, 42 C.F.R. 440.50, 2004)
- Medical or other remedial care provided by licensed practitioners (Act, 42 C.F.R. 440.60, 2004)
- Clinic services (Act, 42 C.F.R. 440.90, 2004)
- Dental services (Act, 42 C.F.R. 440.100, 2004)
- Physical, Occupational, Speech Therapy (Act, 42 C.F.R. 440.110, 2004)
- Diagnostic services (Act, 42 C.F.R. 440.130 (a), 2004)
- Preventive services (Act, 42 C.F.R. 440.130 (c), 2004)
- Immunization services (Act, 42 C.F.R. 441.56, 2004)
The federal Vaccine for Children program provides vaccines for low-income children, and the state Medicaid agency can provide specifics about enrollment in the program.
- Rehabilitative services (Act, 42 C.F.R. 440.130 (d), 2004)
- Transportation services (Act, 42 C.F.R. 440.170 (a), 2004)
- Nurse Practitioner services (Act, 42 C.F.R. 440.166, 2004)
- Private duty nursing services (Act, 42 C.F.R. 440.80, 2004)
- Personal care services (Act, 42 C.F.R. 440.167, 2004)
- Medical Services under the Individuals with Disabilities Education Act (IDEA, 2004)

The Guide suggests that this list is not all-inclusive and school providers should consult with their state Medicaid agency to identify any additional state requirements.

Since the enactment of the Education for All Handicapped Act in 1975 and the IDEA amendments that followed, children who were at one time institutionalized are now mainstreamed into our schools. Students who are in special education have a higher incidence of chronic health conditions, and school districts are providing more school nursing services. Nursing services must be provided to children who are in special education according to Free Appropriate Public Education. Even though these services must be provided to children at no charge to families, school districts are allowed to bill medical assistance for them.

The Medicare Catastrophic Act of 1988 (CMS, 2003) allows Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act (IDEA), formerly known as the Education for All Handicapped Act. This was enacted to ensure that Medicaid would cover health-related services provided under IDEA.

The 1997 Reauthorization of IDEA (IDEA, 34 C.F.R. 300.142, 2004) strengthened the expectation that schools would work closely with the state Medicaid agency. Since that time, many school districts have developed third party reimbursement programs for health-related services provided to students with Individual Education Program (IEP) plans. State Medicaid agencies provide technical assistance to school districts and should be consulted in regard to state-specific requirements and IEP health-related services covered in the state plan.

IDEA (IDEA, 34 C.F.R. 300.24, 2004) describes related services as transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education and includes:

- Audiology
- Counseling
- Early identification and assessment
- Medical services
- Occupational therapy
- Orientation and mobility services
- Parent counseling and training

- Physical therapy
- Psychological services
- Recreation
- Rehabilitative counseling
- School health services
- School social work services
- Speech-language pathology services
- Transportation (such as special or adapted buses, lifts, and ramps)

In the past, school nursing services have been defined under school health services, rather than school nursing services. The Individuals with Disabilities Education Improvement Act (IDEIA) of 2004, Public Law 108-446, signed in December 2004, clearly defines school nursing service as a related service. These services must be provided at no cost to the family. Nursing services that are necessary to assist students in benefiting from their educational plan must be described in the IEP and are reimbursable.

States may differ in coverage of IEP health-related services. It is necessary to consult with the state Medicaid agency regarding covered services.

Early and Periodic Screening, Diagnostic, and Treatments Services

In order for Medicaid to reimburse health care services provided in schools, the services must be included in the federal Medicaid statute and also included in the state's Medicaid plan under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

Schools may determine that it is beneficial to provide EPSDT services to certain populations in order to address the gaps in health care services. The identification and early treatment of health problems promotes school success by remediation of conditions that interfere with learning and by increasing school attendance and time on task.

Eligible children under the age of 21 are entitled to the mandatory Medicaid EPSDT benefit. "The Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program is Medicaid's comprehensive and preventive children's health program that emphasizes the early assessment of children's health care needs through periodic examinations. The EPSDT program is a unique benefit in Medicaid because the scope of required services can be broader than what is otherwise included under a state's Medicaid state plan in general" (CMS, 2003).

State Medicaid agencies cannot require prior authorization for EPSDT screens (either periodic or interperiodic).

Required screening components

1. Screening services
 - Comprehensive health and developmental history, including assessment of physical and mental health development
 - Comprehensive physical exam
 - Immunizations based on the recommendations of the Advisory Committee on Immunization Practices (ACIP)
 - Laboratory tests, including blood lead
 - Health education and anticipatory guidance
2. Vision services
3. Dental services
4. Hearing services
5. Other necessary health care, diagnostic, and treatment services to correct and ameliorate defects and physical and mental conditions identified during screening services.

Third Party Reimbursement Requirements

School districts should consult with the state Medicaid agency regarding state-specific requirements for billing. School districts will need to enroll as providers and obtain a provider number. Some states contract with other insurance companies to provide health care services to Medicaid recipients. In these cases, school districts may need to contract with other individual insurance companies in order to be paid for health care services.

Free Care Rule and Third Party Liability

The Free Care Rule says that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Medicaid should also be considered the payer of last resort and should not pay if another party is legally liable for payment, such as other federal and state programs or third party insurance payers. (CMS, 2003). If a child/student has Medicaid and another insurance policy, the school must first bill the private insurance. If a denial of payment from the private insurance is received, then the school can submit a claim to Medicaid. In order to meet the conditions for Medicaid reimbursement when services such as school-based screenings and other preventive services are offered to all students schools must:

- “1) establish a fee for each service that is available;
- 2) collect third party insurance information from all those served (Medicaid and non-Medicaid); and
- 3) bill other responsible third party insurers” (CMS, 2003).

There are two exceptions to the free care rule:

1. Services provided under IDEA (IEP Health-Related Services)
Schools may bill Medicaid for IEP Health-Related Services provided to children/students in special education even though these services are provided to non-Medicaid eligible children for free.
2. Services provided under Title V: Maternal Child Health Services Block Grant (MCH)
MCH grants provide financial assistance to states for the provision of health services to mothers, children, and adolescents to reduce infant mortality, disease prevention, and access to health care (Davis-Alldritt, 2006).

The Free Care Principle has been the subject of a dispute between the Oklahoma Health Care Authority and the Centers of Medicare and Medicaid (CMS). The Centers for Medicare and Medicaid disallowed \$1,902,390 of federal financial participation (FFP) claimed by Oklahoma under title XIX of the Social Security Act (Act) for the cost of school-based health services (EPSDT services) provided. CMS disallowed the claims on the grounds that Oklahoma did not seek reimbursement for the cost of EPSDT services for students who were not Medicaid eligible. The U.S. Department of Health and Human Services Departmental Appeals Board reversed this disallowance in full, mainly on the bases that there is no statutory regulation in the Act indicating the Free Care Principle, and that requiring the schools to bill the non-Medicaid students is a barrier to the provision of the EPSDT services (DHHS, 2004).

RATIONALE

The responsibility of school systems is to provide education to our children. However, in order for children and adolescents to be safe and successful in school, they must first have their health care needs met. In years past, many of the necessary health care services provided to children were provided in medical settings. School nurses are now providing many of these same services in school settings. Schools are now a part of the health care delivery system and should be reimbursed accordingly for covered services. It is the belief of the National Association of School Nurses that comparable health care services delivered in school settings should be reimbursed.

ROLE OF THE SCHOOL NURSE

School nurses know the value of the services that they provide to children and adolescents and must appreciate the value of these services within the context of the health care delivery system. As providers of health care, school nurses must also determine the monetary value of the services that they provide and recognize that many of these health care services are reimbursable.

School districts that increase revenue streams can use these dollars to support the delivery of health services. Quality health care services provided to students can eliminate or reduce health-related barriers to learning, assist children in being ready to learn, and promote academic achievement.

School nurses need to take a leadership role in the development of third party reimbursement programs by:

- Determining if third party reimbursement will benefit their school district by assessing current health care services delivered and the services that are reimbursable in their individual state by a third party payer (Medicaid or private insurance). If necessary, seek the support and expertise of vendors who can provide guidance to schools and districts in seeking reimbursement.
- Garnering support from the school board, the administration, and the school staff.
- Demonstrating cost benefit to state Medicaid agencies and insurance companies in negotiating contracts with schools.
- Establishing rates based on salaries, benefits, and the costs associated with delivering services.
- Collaborating with other health care disciplines that have reimbursable services, such as physical therapists, occupational therapists, speech therapists, and social workers.
- Establishing a documentation system that meets the requirements for third party reimbursement.
- Promoting the quality of services by developing quality reviews and internal audits.

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Transition Planning for Students with Chronic Health Conditions



Issue Brief

INTRODUCTION

Increasing numbers of children with special healthcare needs and complex medical conditions attend school on a regular basis (American Academy of Pediatrics [AAP], 2008). According to Murphy and Carbone (2011), there are 10 million U.S. children with special healthcare needs. Transition planning refers to a coordinated set of activities to assist students with chronic health conditions move into school, from one school to another, from hospitalization back to school, and from the secondary school system into their next stage of life (Selekman, Bochenek, & Lukens, 2013). It includes coordinated, deliberate and community-based strategies to ensure positive health and academic outcomes for the student with a chronic illness, disability or injury (Craig, Eby, & Whittington, 2011). The registered professional school nurse (hereinafter referred to as school nurse) has the perspective and skills to lead the planning team to address transitions for students with chronic health conditions.

BACKGROUND

Advances in medicine and technology allow most children with chronic conditions to reach adulthood. Changes in healthcare delivery (e.g., reduced hospital stays and increased outpatient care) have shifted the burden of care to the community (Shaw & McCabe, 2008). As a result, students with chronic health conditions may require special accommodations at school particularly when transitioning between developmental stages and life events. Federal laws support transition planning for students with chronic health conditions by requiring schools to provide all students with an equal opportunity to participate in academic, nonacademic and extracurricular activities. The Individuals with Disabilities Education Improvement Act (IDEIA), 2004, entitles students with disabilities and those who need special education to receive the support services needed to have access to a free and appropriate education in the least restrictive environment, preferably in a regular classroom. For those students who do not qualify for special education, Section 504 of the Rehabilitation Act requires that reasonable accommodations be provided so that the student can fully participate in the educational experience (Cartwright, 2007). The Americans with Disabilities Act (2008) prohibits discrimination on the basis of disability.

In addition to support provided by federal law, Lineham (2010) found that planning for timely and seamless transitions should be in place to avoid interruption of students' access to the services needed to fully participate at school. Providing for the health needs of students with chronic health conditions and enabling them to have access to the same educational opportunities as their peers have positive benefits (Wideman-Johnston, 2011). These benefits include enhancing their self-identity and increasing resiliency.

RATIONALE

The goal of transition planning is to maximize the student's health and academic experience. Communication between the healthcare provider and school is critical to raising awareness of the transition needs of the student and determining how to best address these needs (Glang et al., 2008). For example, when transitioning a child into

the school system after a prolonged hospitalization for injury or illness, both the child and the school environment must be evaluated to identify services and accommodations needed for the student to fully engage in his or her educational experience (AAP, 2008).

The time and resources needed to plan and implement transition strategies for the student with chronic health conditions can be a barrier. “With greater numbers of children with chronic diseases and disabling conditions entering the school system and the increasing complexity of these conditions, many issues and problems have developed. The availability of services, designation of responsibility for their payment and provision, and conflicting legal imperatives, as well as other obstacles, result in vastly different services in various communities” (Cartwright, 2007, p. 1220).

Transition planning for students with chronic health conditions must address the following issues:

- Privacy of student health information “ The *HIPAA* Privacy Rule allows covered healthcare providers to disclose PHI about students to school nurses, physicians, or other healthcare providers for treatment purposes, without the authorization of the student or student’s parent. For example, a student’s primary care physician may discuss the student’s medication and other healthcare needs with a school nurse who will administer the student’s medication and provide care to the student while the student is at school.” (U.S. Department of Health and Human Services, 2008, p. 1).
- Transition plans must be individualized. Students with similar medical conditions may respond to and adjust differently as a result of temperament, comorbidities, stage of disease, family factors and social support (Shaw & McCabe, 2008).
- It is essential for the school nurse to lead the school health team. Since school nurses often cover multiple schools, when allowed by district policy and state law, the school nurse may need to delegate nursing tasks in order to implement the transition plan for a student. When nursing tasks are delegated to other members of the school health team, the school nurse remains accountable for the decision to delegate, for training the delegate and for providing ongoing supervision of the delegate (American Nurses Association [ANA], 2012; Kruger, Toker, Radjenovic, Comeaux, & Macha, 2009).

THE ROLE OF THE SCHOOL NURSE

Transition plans for students with chronic health conditions should be developed for each planned transition in collaboration with the healthcare provider, parent/guardian, student, teachers, and other appropriate school staff. According to the AAP (2008), school nurses are positioned to take the lead in making these transition plans. These plans should identify, support, or promote access to needed services and resources both within and outside the school setting. Transition plans should focus on providing the needed accommodations and services to meet academic, social and emotional needs; stimulate academic motivation; and promote adjustment to the school setting (Shaw & McCabe, 2008). The development and implementation of a transition plan can improve the quality of life for the child and his or her family by providing the support needed to promote student health and academic success. Individualized transition planning that is started with the healthcare provider prior to school entry empowers the parents/guardian to clarify the needs of their child and identify preferred strategies to meet those needs (Glang et al., 2008). In addition, the school and school nurse are better prepared to implement the transition plan in a coordinated and seamless manner.

The role of the school nurse is essential in caring for children with chronic health conditions (Kruger et al., 2009). In order to effectively support transitions for students with chronic health conditions, school nurses should:

- Be knowledgeable about applicable local, state and federal law;

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- Maintain clinical competence to provide direct care and/or delegate care for children with chronic health conditions, injuries or disabilities;
- Develop a relationship with the student's healthcare provider and family to assure that the medical orders and resulting IHP are implemented correctly;
- Provide consultation and/or referral to the medical home and community resources (AAP, 2008);
- Identify needs across the coordination team for continuing education regarding chronic conditions (Kruger et al., 2009);
- Influence the development of policies surrounding chronic disease management and coordinated school health programs (AAP, 2008);
- Ensure that there is adequate communication and collaboration between the student and family, healthcare provider, school officials, and providers of community-based resources (AAP, 2008); and
- Ensure continuity, compliance and supervision of care for the child with a chronic condition or injury who attends school (AAP, 2008).

The education system is greatly impacted by children with chronic health conditions. The system must understand and advocate for meeting the healthcare needs and services that these children require. Effective transition planning is essential. Collaboration is a shared responsibility of all professionals involved in the care of children with chronic conditions (Lineham, 2010). Transitioning, whether from school to school, school to adult life or between the hospital and school environment, can significantly affect the physical and psychosocial well-being of students both with and without chronic health conditions.

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National Association of School Nurses

ISSUE BRIEF

School Nursing Services Role in Health Care

SCHOOL VISION SCREENING

INTRODUCTION

Vision screening in schools has a long history, the purpose of which was, and continues to be, the detection and referral for treatment of commonly occurring visual anomalies (Zaiger, 2000, 2006). "Commonly occurring" is defined as a condition whose prevalence is 1% or greater of a potentially-affected population (Timmreck, 2002). Early detection of a vision problem can have educational and behavioral benefits, and certainly has quality of life benefits (AAPOS, 2001; Pizzarello, Tilp, Tiezzi, Vaughan, & McCarthy, 1998). School vision screening is distinct from school vision assessment, which is conducted when a teacher or parent refers a child to the nurse because of a suspected visual problem. Assessment is more comprehensive than screening and considers all available data in formulating a nursing diagnosis (NASN & ANA, 2005).

Traditional school vision screening has focused on the examination of *distance vision* in order to detect myopia, the most common of visual disorders, and to a lesser extent, high astigmatism (Appleboom, 1985). The screening of other visual functions in school, specifically *near vision*, *binocular vision*, and *color vision*, are inconsistent across the states. Ophthalmology and optometry consultants to NASN's current publication on vision screening strongly support the school screening of near vision in young children to detect high hyperopia (Proctor, 2005). In recent years, eye care and child health professionals have vigorously advocated for the pre-school and early school appraisal of binocular vision, primarily to detect conditions causative of amblyopia (AAP, AACO, AAPOS, & AAO, 2003; AOA, 2006; NASN, 2001; U.S. DHHS, n.d.). Screening for color vision anomalies is important to a child's educational success and quality of life (Evans, 2003a,b). Further, the appraisal of color vision is unlikely to occur in any other venue except as necessary for entry into certain occupations (WebMD, 2006).

BACKGROUND

An optimal school vision screening program screens all four visual functions, near, distance, binocular, and color, at least once in a child's school life. The inclusion of near, binocular, and color screening in a screening program rarely increases the school screening time in any substantive way. This is because, except for those children found to have a possible problem, these visual functions need be appraised only once in a child's school life, preferably at the youngest age. If conditions associated with any of these are ruled out, subsequent screening is not indicated. Evaluating appropriate child populations for these visual functions is also good case finding. The only visual function that requires repeat screening is distance vision (Proctor, 2005).

Conditions associated with all four of the visual functions meet the 1% prevalence inclusion criterion for screening. Rates of hyperopia are reported at 2 to 4% among young children (Bullimore & Gilmartin, 1997; Preslan & Novak, 1996). In myopia, rates vary from 8% to as high as 50% within particular populations (Preslan & Novak, 1996, 1998). Astigmatism also has a considerable rate range, from 1% to 33% depending upon the ethnic group screened and the method used (Miller, Dobson, Harvey, & Sherrill, 2001; Morgan & Kennemer, 1997). Anisometropia, a difference in refractive error between the two eyes, is associated with near, distance, or binocular visual problems and has an estimated pediatric prevalence of 2 to 3% (Morgan & Kennemer, 1997). Amblyopia can result from uncorrected disorders of near, distance, and binocular vision, and has a prevalence of 2 to 5% among pediatric groups (Bacal, Roust, & Hertle, 1999; Ferebee, 2004). Esotropia and exotropia, as types of strabismus, have a combined prevalence of about 5% (Ferebee, 2004). Finally, color deficiency and color absence are found among 6% and 2% of male children, respectively (Evans, 2003 a,b).

Risk factors for most of the aforementioned conditions include family history, age, ethnicity, gender, chronic disease, poverty, a history of poor health care, and child abuse among other factors. Genetic predisposition is an important predictor for the development of myopia, hyperopia, astigmatism, and strabismus (Frederick & Asbury, 2004). Certain conditions are more prevalent among some ethnic groups than others: myopia is commonly seen among people of Asian and Mediterranean heritage, astigmatism among Native Americans and Jewish populations, and hyperopia among Caucasian and African American populations (Bullimore & Gilmartin, 1997; Chung, Mohidin, Yeow, Tan, & O'Leary 1996; Kang, Park, & Kim, 2003). There are small but significant gender differences in hyperopia with the condition somewhat more prevalent among females (Murthy et al., 2002).

A number of chronic or genetic diseases and pre- or perinatal circumstances also increase a child's risk of the development of a vision problem. Some of these are diabetes, hydrocephalus, prematurity, cerebral palsy, fragile X syndrome, mental retardation, and low Apgar score (Chatterton, Kaup, & Swanson, 2006; Crawford, 2005; Kuntz, 2006; Selekman & Gamel-McCormick, 2006).

Poverty, a history of poor health care, especially in the preschool years, and violence against children similarly increase the likelihood of the development or the delayed detection of some visual conditions as a result of nutritional deficiency, absent well child care, deprivation, or direct trauma to the eye (Kerr & Tappin, 2002; Yoo, Logani, Mahat, Wheeler, & Lee, 1999). Children who are recent immigrants are also more at risk for undetected health problems (Mazyck & Rivera-Matza, 2006).

The cost to the U.S. health care delivery system is substantially less when vision screening takes place in school rather than elsewhere in the health care delivery system (Fryer, Igoe, & Miyoshi, 1997). The same findings hold true for European countries where similar studies have been conducted (König & Barry, 2002). With regard to treatment, all the conditions noted thus far are amenable to traditional therapies, e.g., glasses/contacts, surgery, and/or education. Alternative therapies are also available, a few of which have been found to be efficacious, others of which are costly when compared to equally effective traditional therapy, such as glasses (Proctor, 2005). Nonetheless, research on the efficacy of alternative therapies, employing well-designed, carefully controlled comparison investigations, is encouraged.

RATIONALE

Schools have a long-established tradition of engaging in vision screening. Furthermore, school vision screening has proven to be effective in detecting previously undiagnosed conditions (Yawn, Lydick, Epstein, & Jacobsen, 1996). In view of the importance of early intervention and the need to detect visual anomalies early in a child's life, the National Association of School Nurses (NASN) supports the implementation of vision screening programs that place emphasis on the evaluation of the vision of young, at-risk, and never-screened children for near, distance, binocular, and color visual function, and then periodic appraisal of the distance vision of older, previously-screened children.

NASN endorses specific education and training for school vision screeners, especially nurses, to include didactic content and laboratory practice, and recommends the use of only well-prepared individuals as vision screeners. NASN further supports the implementation of vision screening programs in states and school districts that currently do not have such, and encourages nurses in states with established laws or guidelines to evaluate state or district screening parameters for their congruence with contemporary national recommendations and practice needs, promoting changes as necessary.

Finally, NASN encourages school nurses to investigate some of the new technologies available for school vision screening. Two more recent technologies are *photorefractive imagers* or photometers (e.g. Photoscreener® and Visiscreen-100®) and *portable autorefractors* (e.g. R-Max +®, SureSight®). Photometers are effective in detecting alignment deviations, cataracts, and retinoblastoma, and autorefractors in identifying refractive errors, including anisometropia and astigmatism (Kelly, 2006; NEI, 2003). Although research on the efficacy of both continues, these technologies are quite accurate. Even though they are expensive, their use could greatly improve the efficacy of a vision screening program and therefore, may be well worth the cost.

ROLE OF THE SCHOOL NURSE

Specific aspects of the nursing role may include:

- When possible, establish vision screening programs for early child and vulnerable child groups that assess near, distance, binocular, and color vision.
- Employ the most accurate yet practical techniques, equipment, and tests for the age group and visual function being screened.
- Be alert to the higher probability of visual problems among children with certain chronic, genetic, and congenital conditions; socioeconomic backgrounds; or parents or siblings with an identified vision problem.
- Assist families in understanding their children's conditions and in accessing care through referral to vision-specific programs, agencies, and services.
- Encourage the examination of a child's eyes by an eye professional at least once in a child's school life.

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Adopted: June 2001
Revised: June 2006

Non-Patient Specific Epinephrine in the School Setting

Board Statement



The National Association of School Nurses supports school nurses in the administration of non-patient specific epinephrine orders in life threatening situations in the school setting, and further, NASN supports maintaining a supply of stock epinephrine in the school setting.

January 31, 2011

The Use of Restraints or Seclusion in the School Setting

Consensus Statement



It is the opinion of NASN that promoting the safety and health of all students is vital to the educational success and positive development of children. NASN believes the use of restraints or seclusion can potentially cause injury or death to children and therefore should only be used as a brief intervention where there is a risk of imminent danger to the child, staff, or classmates.

In order to meet the safety and health needs of all students including those that display at risk behaviors, NASN supports;

- Every child having access to a school nurse
- Prevention strategies including positive behavioral support training and de-escalation methods for all school staff and administrators
- Adequate, consistent, staffing ratios in all classrooms- especially those working with at-risk populations
- Policy for reporting when restraints or seclusion have been used- including report to parent/guardian, school administration, and an independent group

RATIONALE

- School nurses advocate for the health and wellbeing of all children-with or without disabilities
- School nurses are essential team members in developing school safety and wellness policies
- School nurses provide assessment of the physical and mental health needs of students and staff if it becomes necessary to use restraints or seclusion to protect the safety of the student, staff, classmates or property
- School nurses are a resource to school administration and the community, when investigating and implementing best practices including positive behavioral support and de-escalation techniques

Approved by the NASN Executive Committee August 2009



Safe School Nurse Staffing for Quality School Health Services in Schools

Joint Consensus Statement

SUMMARY STATEMENT

It is the opinion of the National Association of School Nurses (NASN) and the National Association of State School Nurse Consultants (NASSNC) that adequate staffing of registered, professional school nurses (hereinafter referred to as school nurses) in all schools is of critical importance in order to provide safe, effective, and timely care for all students. The pressure to reduce both health and education budgets has led to school nurse staff and programs being eliminated. A 2012 questionnaire by the National Association of School Nurse Consultants (NASSNC) found that 55% of the state school nurses consultants who responded reported that some school nursing positions have been dissolved or replaced with unlicensed staff, medical assistants, emergency medical technicians, certified nursing assistants or volunteers. Therefore the school is without a school nurse to attend to the health needs of students or to supervise unlicensed personnel staffing health rooms. Additionally, the questionnaire found that 68% of respondents reported that school nurses and others have provided medication administration training to unlicensed staff in districts where there are no school nurses to provide services (NASSNC, 2012).

The NASN and NASSNC strongly oppose a decrease in school nurses as student health needs are increasing.

- Every child should have access to a school nurse.
- Appropriate school nurse staffing is essential to the delivery of quality care and positive student health outcomes (ANA, 2005a).
- School nurses are the health experts in schools, with the education and experience in pediatrics and public health to provide safe nursing care for students. School nurses work within the scope and standards of school nursing practice (ANA/NASN, 2011).
- Nurses are the most trusted health professionals in the US, with eighty-one percent of Americans consistently expressing that they believe nurses' honesty and ethical standards are high or very high (Jones, 2010).

RATIONALE

NASN and NASSNC believe that it is critically important that:

- Students with access to school nurses have better school attendance and lower dismissal rates than students who do not have access (Pennington & Delaney, 2008). Student absenteeism has a direct association with poor academic performance (Weismuller, Grasska, Alexander, White, & Kramer, 2007).
- Students with special health care needs require nursing, instructional and behavioral support, and may need an Individual Education Plan (IEP) or Section 504 Plan to access a free and appropriate education in the least restrictive environment (Forrest, Bevans, Riley, Crespo & Thomas, 2011). School nurses are

essential members of the school team to determine and implement the accommodations required for success (Kruger, Toker, Radjenovic, Comeaux, & Macha, 2009).

- Students with special health care needs benefit from school nursing care and case management as they are at greater risk for lower student engagement, bullying, disruptive behaviors that affect social competence and lower academic achievement (Forrest et al., 2011).
- School nurses are equal partners with other school professionals (ANA, 2012) in determining the health needs of students and the level of nursing care needed based on data, student and community health assessments and health conditions in order to ensure safe care and positive student health outcomes.
- School nurses are the school professionals best prepared to determine the level of nursing care in school for the 19.2% (14.2 million) school-aged children with chronic health conditions involving special health care needs (Bethell et al., 2011).
- School nurses in schools with adequate staffing have more direct student contact, greater involvement in developing the IHP (Individual Healthcare Plan) and IEP, regular contact with providers, and provide care for children with complex health conditions (Kruger et al., 2009).
- School nurses promote a healthy environment in school and in the community by identifying health issues via screenings, health assessments, health promotion activities, and health education (Schoessler, 2011).
- School nurses must be the health professional with oversight and implementation of the medication administration process in compliance with individual state laws and regulations. Medication administration to children is a very serious role for the school nurse as medication errors in children potentially result in greater harm than to adults (Gonzales, 2010).
- School nurses have a unique contribution to offer concerning children's health and safety whether through advocacy efforts or standards of practice. For example, school nurses use their skills and judgment to detect and refer for treatment potential vision deficits in students, enabling students to learn (Basch, 2011).
- School nurses have the education and training to serve as healthcare team leaders and should, and are often required, to provide supervision and direction if a LPN/LVN is utilized as a member of the school health care team. The extent of nursing tasks that can be performed by the LPN or LVN is determined by each state's scope of practice and standards and/or applicable state specific statutes (ANA, 2005b). In many states the LPN/LVN must work in a team relationship with a registered professional nurse.
- Medicaid and private health insurers benefit from the disease management and preventive health care services provided by school nurses. Schools alone cannot continue to subsidize the health care needs of students - Medicaid and private insurers must step forward and meet their responsibility.

Adopted: May 2012

For more information see: [NASN Role of School Nurse Position Statement \(2011\)](#).

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National Association of School Nurses

Resolution

Access to a School Nurse

Whereas, every student deserves access to a school nurse; and

Whereas, there are approximately 60,000 registered nurses in the United States public school system who care for more than 52 million students; and

Whereas, research has shown that school districts with adequate nursing coverage have fewer absences, a decreased drop out rate, and higher test scores; and

Whereas, the professional registered school nurse is a vital part of insuring the optimum health and well-being of all students and staff by offering health information, health instruction, and quality health services; and

Whereas, Title V funds from the (Elementary and Secondary Education Act (ESEA) can be used to fund school nursing services; and

Whereas, the United States Supreme Court ruling in Cedar Rapids Community School District vs. Garrett F. held that the Individuals with Disabilities Education Act (IDEA) requires school districts to provide nursing services when such supportive services are necessary in order for students to access and benefit from their educational program; and

Whereas, in the event of any emergency affecting schools in the United States, school nurses would be among the first medical professionals to respond, thus voluntarily placing themselves at increased risk; and

Whereas, the Asthma and Allergy Network, Mothers of Asthmatics (AANMA) and the Centers for Disease Control (CDC) recognize that the need exists for a full-time registered nurse all day, every day for each school;

Be it resolved that school districts should provide a full-time registered nurse all day, every day for each school.

Adopted: June 2003



National Association of School Nurses

Resolution

Global School Nursing

Whereas, the National Association of School Nurses (NASN) recognizes the growing impact of the global community on the health and safety of all children, and

Whereas NASN recognizes that, with the increase in mobility across the world, children cross borders; and disease, health concerns and environmental issues know no boundaries, and

Whereas NASN recognizes that school nurses throughout the world have a unique contribution to offer to school nursing and the concerns of all children's health and safety whether it be through advocacy efforts or standards of practice.

Now, Therefore, Be It Resolved that in an effort to meet the needs of all students globally, NASN will continue to encourage the expansion of school nurses' international involvement.

Adopted: June 2010



National Association of School Nurses

Resolution

Overweight and Obese Children and Adolescents

- Whereas, The fastest rising public health problem in our nation is obesity; and
- Whereas, In the last two decades the percentage of overweight children has almost doubled and the percentage of overweight adolescents has almost tripled; and
- Whereas, Thirty-two percent of children and adolescents are overweight or obese; and
- Whereas, Children from diverse ethnicities are unduly effected by this epidemic; and
- Whereas, Childhood overweight accelerates the development of chronic diseases such as hypertension, type 2 diabetes, cardiovascular diseases, sleep apnea, gall bladder disease, asthma, cancer, and others; and
- Whereas, Most children spend a large portion of their day at school, and schools are a key setting in which to implement strategies to address this issue; and
- Whereas, The school nurse has the capacity to reach a large number of youth from diverse groups; and
- Whereas, Obesity must be addressed through the combined effort of the entire healthcare and larger community; therefore be it
- Resolved,* That the National Association of School Nurses supports the First Lady's Initiative to reverse the tide of child and adolescent overweight and obesity; and
- Resolved,* That school nurses have the expertise to meet the needs of overweight and obese children and to promote and advocate for healthy lifestyles for all students; and
- Resolved,* That school nurses and NASN collaborate with students, parents, school community, community at large and health care community to provide education and resources to address this public health issue and promote a culture of health in schools; and
- Resolved,* That the National Association of School Nurses can provide the education and skills for school nurses in the prevention and intervention of overweight and obesity in children and adolescents.



National Association of School Nurses

Resolution

Vending Machines and Healthy Food Choices in Schools

Whereas, every student deserves access to healthy food and beverage choices in school; and

Whereas, the rate of obesity is increasing in the student population; and

Whereas, childhood overweight accelerates the development of chronic diseases such as Type II Diabetes, cardiovascular diseases, sleep apnea, gall bladder disease, asthma, cancer, and others; and

Whereas, 43% of elementary schools, 74% of middle schools, and 98% of high schools have vending machines, school stores, or snack bars where students can purchase food or beverages that are in competition with federally supported child nutrition programs (*CDC School Health Policies and Programs Study, 2000*); and

Whereas, more students are choosing to purchase foods from ala carte choices and vending machines that compete with the USDA child nutrition programs and have no federal nutrition guidelines (*CDC School Health Policies and Programs Study, 2000*); and

Whereas, it has been found that 98% of school-aged children in the United States do not meet the requirements of the Food Guide Pyramid for all five food groups (*Foods Sold in Competition with USDA School Meals Programs: A Report to Congress, 2001*); and

Whereas, the Health People 2010 report recommends that schools promote healthy eating to promote good health and ensure adequate nutrition that assist with normal development and academic performance or success; and

Whereas, children who are offered nutritious foods and beverages will eat these foods and develop good eating habits (*Evaluation of the USDA Fruit and Vegetable Pilot Program: Report to Congress, 2001*); and

Whereas, the school environment should be consistent with the message that good nutrition is best for children's health now and throughout adulthood;

Be it resolved that healthy/nutritive food and beverage choices be made available in all school vending machines, school stores, snack bars, and any area in schools where food is sold; and

Be it further resolved that foods of minimal nutritional value not be available in the educational setting during the school day.

Adopted: November 2004